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Muslim Women's Mental Health

A community-based research project

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ABSTRACT

This community-based project solicited the first-hand experiences of Muslim women and front-line mental health workers to understand what service gaps are present in the functioning of mental health services located in the Greater Toronto and Hamilton Area (GTHA). The primary goal of this project was to enhance inclusivity in the mental health services landscape with information on how to create a more equitable system for Muslim women and to support the development of tools and resources to enhance the work of service providers.

This research project collected qualitative data from three focus groups with 13 self-identified Muslim women as well as one-on-one interviews with 10 mental health professionals who have provided mental health supports and services to Muslim women in the past. Themes in the report include: the role that stigma and external barriers continue to play in preventing Muslim women from accessing mental health support, the importance of providing culturally sensitive patient care and the need for diverse service providers at the community level.

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INTRODUCTION

Recent research on the prevalence of mental illness in Muslim communities has identified a strong relationship between experiences of discrimination and mental health challenges (Phillips & Lauterbach, 2017; Shattell & Brown, 2017). Muslim women may be in a particularly vulnerable position vis-à-vis religious or racial discrimination in part because symbols of faith, such as the hijab, make them more visible as Muslim and in part because a woman's identification as Muslim intersects with gender and race. However, members of Muslim communities may be less likely to engage in help seeking due to long-standing mental health stigma in their communities, distrust of the current health system, and/or limited supports in languages other than English.

Researchers and mental health professionals are still learning about what aspects of the mental health care system motivate or discourage Muslim women's engagement with mental healthcare services. This community-based study solicited the first-hand experiences of Muslim women and front-line mental health workers to contribute to understanding Muslim women's mental health care journeys, and explores how mental health services and community organizations in the Greater Toronto and Hamilton Area (GTHA) can better engage and support Muslim women.

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BACKGROUND

Experiences of racism, migration and stigma as social determinants of mental health

Social, cultural and economic life have a profound influence on our mental and emotional well-being. There are good reasons to think that Muslim women in Canada experience mental health stressors through multiple, entangled aspects of their lived identity: they are women; they are often visible as racialized and religious minorities; they are often connected to cultural and religious communities with complicated migration experiences; and they have cultural backgrounds that can involve stigma towards mental health problems.

Experiencing racism, whether at the societal, institutional or individual levels, is likely to have negative effects on an individual's mental health, and these effects can be long-term (Phillips & Lauterbach, 2017; Shattell & Brown, 2017). A considerable amount of research has investigated racial discrimination and how this intersects with other factors such as socio-economic status and gender. For example, some studies confirm that different ethnic groups face different degrees of discrimination, and socio-economic status often intersects with race (Block, Galabuzi, Weiss & Wellesley Institute, 2014; Hum & Simpson, 2000; Yap, 2010).

Many Muslim women in Canada are Canadian by birth, but migration histories are common in their communities and family backgrounds. Delara (2016) looked at the determinants of immigrant women's mental health through a cultural and social standpoint, and in terms of the healthcare system. Specifically, cultural identity plays a part in shaping their responses to mental illness, including their responses to stigma and their decision to seek support or not. Social networks and overall social integration into a new country are also a determinant of mental health. Immigrant women can be at a disadvantage in social spheres as they navigate gender roles between their culture and that of the mainstream, face marginalization, and often have a lower socioeconomic

status than their native-born counterparts (Delara, 2016). Finally, the healthcare system can pose another barrier if healthcare providers are not equipped to respond to the cultural, psychological and spiritual needs of immigrant women, or face communication challenges with these groups (Delara, 2016; Ahmed et al., 2016).

The 2012 Canadian Community Health Survey looked at the prevalence of mental health consultation among Ontario residents. 57.89% of Ontario immigrants contacted their primary care physician within the year for mental health support, significantly higher than the Canadian-born populations (45.31%). Education level, employment status, food insecurity, years since immigration, and age at time of immigration were determining factors of mental health consultation for immigrant populations (Islam, Khanlou, Macpherson, & Tamim, 2018).

Muslim women come from extremely diverse ethnic backgrounds, but in the Greater Toronto Area and among the research participants in this project, South Asian backgrounds are common. Ekanayake, Ahmad, & McKenzie, (2012), through in-depth cross-sectional interviews, sought to understand the causes of depression for South Asian women in Toronto, Canada. They identified three major factors: family and relationships, culture and migration, and their socioeconomic status. The majority had experienced domestic abuse or other marital and family-related issues. The challenges associated with migration and navigating their culture and identity in Canada were also identified as major factors that affected their mental health. Islam, Multani, Hynie, Shakya, & McKenzie (2017) found similar results for South Asian youth in Toronto, who faced mental health stressors associated with intergenerational and cultural conflict, family and relationship challenges, financial stress and academic pressure.

Many studies have also noted the detrimental effects of mental health stigma, yet it is common among almost all groups and can be influenced by religion, culture and lack of access to support (Phillips & Lauterbach, 2017). Fear of social exclusion and isolation from one's own community is also a significant concern that impedes help seeking. For instance, Roberts et al. (2015) found that for some ethno-cultural communities, mental illnesses suggest personal weakness and a deficiency of the individual; they are a source of personal shame surrounded by a culture of silence—crucially, these factors make it more difficult for religious and cultural minorities to seek help. In some communities, stigma is so great that people experiencing mental illness will forgo discussing it with family and community to the point of social exclusion/isolation, even though families are otherwise seen as a strong source of support (Ekanayake, et al., 2012).

Islamophobia and racism: the Muslim experience

There are good reasons to be concerned with the mental health stress caused by faith-based discrimination of Muslim women in Canada. Recent academic research and federal statistics suggest that hate crimes and aggression motivated by Islamophobia are on the rise in Canada and the US (Statistics Canada, 2017; Council on American Islamic Relations, 2017). Discrimination against Muslim immigrants in particular is driven by ongoing discourses around terrorism and conflicts between Israel and Palestine (Ciftci, Jones, & Corrigan, 2013).

In a Canadian context, the Environics Institute (2016) conducted a survey of Canadian Muslims. From those surveyed, six in ten were very (27%) or somewhat (35%) worried about discrimination against Muslims in Canada, a slight decrease from the 2006 survey that showed 66% expressed this view. Most surprisingly, 42% of Muslim women (compared with 27% of men) say they have experienced some form of discrimination or ill-treatment during the past five years. This indicates that Muslim women worry far more about discrimination, unemployment and Islamophobia than men. The 2011, Statistics Canada National Household Survey, showed that the unemployment

rate for Muslims was 14% per cent, compared with the national average of 7.8% despite Muslims having high levels of education. Further to the survey, the Canadian Council of Muslim women (2014) released a report stating that between 2001-2011 Muslim women encountered more difficulties in the labour market than other communities with similar demographic and educational profiles, despite favourable changes in the labour force.

Statistics Canada data reveal that in 2015, 53% of victims of hate crimes were female, compared with 40% in 2014. Muslim women can be more vulnerable because the practice of wearing hijab, a tangible marker of difference (Droogsma, 2007; Rassool, 2015), marks a public and visible expression of their religious identity. There has been a sustained scholarly examination of the socio-political conditions that have influenced this increase in discrimination and aggression (Kaplan, 2007), and a growing interest in the mental health implications of the rise of Islamophobia (e.g., Amri & Bemak, 2012; Phillips & Lauterbach, 2017).

There is also extensive research demonstrating that members of communities of faith in Canada are less likely to access mental health services due to mistrust of and/or lack of familiarity with the system (e.g., Ekanayake et al., 2012; Fuller-Thompson et al., 2011; Shakya et al., 2010). A study by Abu-Ras et al. (2008) found there to be a lack of experienced mental health workers familiar with Islam and Islamic culture, and this lack of services led some Muslims to seek mental health care from spiritual leaders or primary care physicians in their communities rather than from mental health providers.

The experiences of Muslim women in this regard are less readily solicited and thus less well understood despite this group's increased vulnerability. While researchers, advocates and service providers are starting to understand the impact of Islamophobia on the mental health of Muslim women, we are still learning about what aspects of the mental health care system motivate (mis)trust and discourage Muslim women in particular from interacting with available supports. The consideration of how safe and appropriate mental health services are for Muslim women is only now being considered in the literature (e.g., Saleem & Martin, 2018; Shattell & Brown, 2017). Considering that Canada expects to have welcomed 450,000 refugees and 3,000,000 immigrants over the next 10 years, it is vital to further consider the gaps in and barriers to access from the perspective of communities of faith and of those who provide and can improve mental health services.

Muslim identity and intersectional perspective

Individual identity, and the way that intersectional identities exist in society, are critical factors to understanding mental health and access to support. Factors such as gender, culture, race and migration status, and socioeconomic status impact the lived experiences of individuals, making them critical determinants of physical and mental health.

One study in the United States, which studied the immigrant Muslim community there, noted various emerging challenges for this population, and particularly challenges relating to identity (Kaplan, 2007). Kaplan notes that, in particular, navigating identity and social integration is a particular challenge for second-generation Muslims in the United States. Rather than identifying fully with their parent's culture, or becoming part of the so-called mainstream, second-generation

Muslim immigrants can create a hybrid American-Muslim identity, synthesizing both values (Kaplan, 2007). However, these identities must be considered in the broader societal context, and while immigrants, particularly racialized immigrants in the West are challenged with finding their own identities, they must also struggle with and against the labels that are imposed upon them by society (Droogsma, 2007).

Cultural sensitivity and addressing barriers to mental health services

An understanding of the complex ways that Muslims shape their own identities is important for service providers, along with cognizance of differences due to race, ethnicity, gender, ability and migration story. Cultural, religious and political environments within which a patient receives care are all at play in the development of a culturally sensitive, anti-oppressive approach (Akram-Pall & Moodley, 2016). In particular, delivering care to Muslim clients requires awareness of the implications of their faith, which may involve needs for modesty and privacy, dietary and medical requirements, and the importance of spiritual incorporation into clinical practice (Rassool, 2015). After the 9/11 terrorist attacks in 2001, New York's Muslim communities turned to mosques for relief, but were hesitant to seek services from the broader community (Abu-Ras et al., 2008). Mistrust of the healthcare system can also pose a major barrier to Muslims seeking treatment. Unfortunately, due to factors such as language barriers, Muslim immigrant communities in particular are faced with less access to mental health supports than the broader population (Ciftci, Jones & Corrigan, 2013). There is a need for more research on the mental health needs of Muslims, and policy must ensure that interventions are local, targeted to this population and culturally relevant (Ciftci, Jones & Corrigan, 2013; Amri & Bemak, 2013; Karasz et al., 2016).

PROJECT DESIGN

The primary goal of this project was to explore the first-hand mental health and mental health services experiences of Muslim women in the Greater Toronto and Hamilton Area (GTHA). In drawing on the first-hand experiences of those who access services and those who provide services, it aims to develop a better understanding of whether current services offer culturally appropriate, faith-informed services for Muslim women and to enhance decision-maker and practitioner understandings of how we can better support this community.

This project asked Muslim women about their experiences accessing mental health services in the GTHA, and asked them to share their feeling and the challenges they face as Muslim women in accessing supports. We also took the opportunity to ask service providers to describe their experiences providing mental health services in the GTHA and to share their insights into the challenges that Muslim women may face in accessing supports.

Methods

This project collected qualitative data from three focus groups with 13 self-identified Muslim women as well as one-on-one interviews with 10 mental health professionals who provide mental health supports and services.¹

¹ All participants gave their informed verbal consent to participate and participants who were interviewed in person gave their written consent to participate. Interviews and focus groups were conducted by the Research Assistant; all interviews and focus groups were audio recorded and transcribed by the RA or by a third-party transcriber. Ethics approval was granted by the Community Research Ethics Office (CREO).

For the focus groups, we solicited participation from Muslim women who were at least 16 years of age, were seeking or currently accessing services in the GTHA and who identified positively with mental health issues or mental illness within the past two years. Participants were asked to share the details of their experiences with mental health services, including in relation to their identification as Muslim women and as women of colour, with a view towards enhancing understanding of what service gaps and barriers are present, particularly in terms of the intersection of gender, race and faith.²

Focus group participants were not required to disclose any diagnosis or disclose the name of any mental health services they currently or have tried to access, and it was not necessary for participants to be Canadian citizens or permanent residents.

In addition, we conducted one-on-one, in-person, semi-structured interviews with 10 individuals who provide or manage mental health services across the GTHA. Mental health professionals were purposively sampled from the full range of professionals working in the GTHA, and included, for example, psychiatrists, psychologists, counsellors, and social workers who had expertise serving the Muslim community. These service providers had an awareness of Islam, of Islamophobia and its impact on Muslim women. They were asked about their perception of what gaps in and barriers to service are present in mental health, their awareness of the potential impact of Islamophobia on mental health, and how they have amended their services to engage with this community, or what training or guidance they receive to support Muslim women living at the intersection of gender, race and faith (the interview guide is attached as an appendix to this paper).

Participants were recruited primarily through snowball recruitment using e-mail and through social media posts containing information about the study.

The interviews and focus groups were audio-recorded and transcribed, and the transcripts were analyzed for thematic content by identifying repeated words, terms and concepts, including where the dialogue of the transcript indicated that participants themselves recognized commonalities between their experiences (by expressing agreement or joining on additional observations).

RESULTS

Themes

The results of the focus groups and interviews present several well-developed and consistent themes regarding the experiences of mental health and mental healthcare in our sample of Muslim-identifying women. Experiences of discrimination, including faith-based discrimination, are present, but not necessarily the most salient experiences that participants (and care providers) could name and wanted to discuss on the subject. Rather, they formed part of a broader, active negotiation between multiple sets of relationships, within families, religious and cultural communities, workplaces and public spaces, and systems of health care – in search of understanding, acceptance and support.

² Focus groups took place in person at the CMHA National offices in downtown Toronto. Participants were provided refreshments, public transit reimbursement and given a \$20 honorarium in gratitude for their time.

The analysis here is divided into the following themes:

1. Cultural connections: barriers and enablers of good mental health care, among care providers and communities
2. Judgment and stigma: both medical and religious experiences of stigma, towards the self and towards one's own community
3. Caring and acceptance: finding what works, in health care, spiritual practice and family conversations about mental health.

In the sections below we use substantial direct quotation to illustrate our analysis of the conversations, making the most of our relatively small sample size by allowing the fullness of the narratives offered by participants to tie together our analytical categories. Due to the small sample size and the focus of our report, we have not included a separate section for results from mental healthcare providers, including their comments where they touch on the themes of the focus groups, but centering the first-hand experiences of the Muslim women participants.

Cultural connections

Muslim women in our GTHA sample experience connections of religion, culture and identity as significant in their mental health journeys, but in a multi-valent way that both helps and hinders these journeys. The value of these connections to participants was less about shared religious beliefs than about the comfort of shared experiences. These connections were seen as an asset in therapeutic and care relationships. But cultural connections can also be perceived as a limitation, as threat or as an unwelcome complication to care-seeking, particularly the notion that in tightly-connected minority communities the privacy of health-related information isn't assured.

Is it better to access care through a provider that shares your ethnic, cultural and religious background? The consideration of this question, and how answers might vary, was a consistent lens through which Muslim women who shared their experiences in focus groups discussed their mental health experiences, and there was no straightforward answer.

For several participants the absence of any such connection in care relationships was a significant barrier to effective mental health care:

“The only therapist ... that we had access to as part of work benefits was an old, white lady, I'm just going to say it. And I went to her twice and never went again... I found absolutely no value because she understood nothing of... my background and what I was going through and family...”

“Even the most understanding therapists, they would always have some kind of picture of what my culture is. And it's not that. You don't understand who I am. You don't understand where I come from.”

“[With] Canadians... identity is so secular that when you start talking about faith ... people ... get so shaky and scared and... they're like, but what do you mean you can be Muslim and have sex?... you're atomising [*sic*] an entire group of people. We now have trauma-based therapy... but there also needs to [be] an anti-oppressive therapy... the way that people are trained has to have a huge overhaul.”

These experiences of cultural stereotyping or a “picture”-based understanding of Muslim women clients led to an perceived inability to connect women's particular mental health stressors with positive solutions:

“When you go to your therapist and you say things like [“I had tough conversations with my dad...”]; it’s not offering you to sit and blame my dad for this problem, because you’re not fixing the problem for me. I understand where my dad comes from; you don’t understand my culture. So... it’s like you’re paying them \$100 to teach them something. Like I’m paying you to tell [you] about myself, instead of getting support.”

“I don’t think [the psychiatrist] could understand the family dynamics... she was like, well if that person is [harmful] you don’t need to talk to them. I’m like, ‘That’s not how it works. Right?... That’s not solving the issue.’ You’re going to give me coping strategies and things to implement, but I’m also going back into the household that thinks a certain way about when I have an anxiety attack... there’s only so much that I can cope with, but I’m going back into the same environment.”

“The solutions that were being suggested were ones that would just make me fight with my family. It wouldn’t be uniting. ... I’ve considered a lot of things and the advice she’s giving me is very good but it’s not something that I can use.”

“Therapy is great because it normalizes things, but it’s also ... even more effective if we can access it... with someone who really understands the culture... My therapist is white; she’s absolutely amazing, honestly, but it’s just... I can’t take her advice when it comes to family stuff.”

By contrast, feeling that one’s care provider had some connection to one’s own experience was experienced as a success factor in therapy. There were several opinions on what this connection should best consist of, from specific shared cultural backgrounds to more general experiential categories such as poverty and/or racialization.

“Having a therapist that understands and can validate from the beginning can really set the course for whether you believe therapy works, whether it does work, whether you want to put in the work for it... my current therapist is Muslim, but like more spiritual, so understands everything.”

Fostering that connection might mean investing in mental healthcare capacity within Muslim communities:

“Some Muslim women [in] Ottawa... they’re two Muslim therapists, trauma-informed work, and they do both pro-bono stuff, but they also have a business. They have packages for therapists, and then also for non-clinical workers, on [cultural competence]. When people ask me, I’m like ‘hire them and pay them!’ No model’s going to be perfect, but if someone has a model that seems to be working, invest in that.”

Service provider interviews also addressed how cultural competence is a key component of effective mental health care, including:

“Cultural competency...that would be the umbrella term... It often comes up...about...how it’s different [it is] to come to a Muslim person or a South Asian person because they don’t have to explain everything. They don’t

have to....share their contacts or the stories that they've grown up in. It's sort of....implied and understood in a different way. Not to say that everyone is the same in our culture, but....there's a certain complexity that everybody faces. And so there's more understanding of it.”

“But when there are services linguistically and culturally appropriately services... they do feel better.”

“People need the cultural sensitivity to be sensitive around the cultural needs... and for these people and lots of people will be comfortable with them and...more cultural sensitivity and...and accommodation and...understanding this...really need.”

Connection might also be fostered by identifying particular aspects of personal experience, not necessarily from finding a therapist from one’s own specific background:

“[A nurse who was looking for a counsellor for me] said... ‘what is most important to you? Is it the religious aspect or is it the cultural aspect?’ ... If I have to choose, I’ll choose the cultural aspect because there’s a better chance of finding cultural than religious... and the Arab culture is also different from East Asian or whatever... it took her a while to find one, but she found a Lebanese-Italian counsellor, who was not Muslim, but very understanding of the culture. She knew Arabs and she had interacted with Egyptians, so she knew when I said, ‘My mom does this and my mom says that’, she understood.”

“When I was looking for someone, I was very clear to the doctor:... ‘I don’t want to talk to a white woman.’ ...It needed to be a woman. ... It doesn’t necessarily need to be someone who is exactly me... I maybe need someone objective or just someone different. But I need them to understand lived experiences of poverty or being racialized or a different cultural lens.”

“I think for me, I just want someone who’s been through some shit... someone who understands... and I think it’s just broad themes of marginalization... I think I would want them to be racialized. I would want them to be a woman, but I don’t need them to be Muslim. I just need someone who can process and come up with actual, meaningful solutions to me feeling the pressures of being a marginalized person here.”

“you want them to be similar enough, but also different enough that you can be comfortable speaking up. I found that [my therapist’s mixed background was] very helpful because she still had... the Western piece, but she knows what Arabs sound like when they’re talking and what Arab moms do and say.”

The conversation about cultural connection and therapy had another side, however, and the focus group participants shifted more than once between seeing this connection as desirable and seeing it as threatening. Wanting to be understood in a deep way by interlocutors such as therapists, Muslim women were also wary of being exposed to unsympathetic community members. Mental health as a medical and humanistic concept was universally

accepted and regarded as positive by our sample of informants, which is not necessarily the case in their networks of community and family support. The conflict was not an internalized one between Islamic and Western psychological ideas of emotional wellness, but rather centred mostly on the effects of tightly-knit ethnocultural communities:

“On my most recent leg of looking for a therapist, I had found a therapist who ... spoke Arabic, who was Muslim, who was from an adjacent community, and it started off with, ‘oh my God, I found the therapist, two days and ... everyone will know.’ And... I cut it off. I sent a very enthusiastic email and then I ghosted. ... You have my first name, my second name, where I’m from, who I know, like [six degrees of] separation and it infiltrates it.”

“It’s weird because I was outed to someone who knows my parents, by a queer Muslim woman, who is supposedly feminist. This woman gave me a mental health crisis. They just assume that because we’re Muslim we’re sisters and you get me... that happens a lot of times for Black women, where it’s like ‘oh, they’re Muslim, we’re going to feel like our experiences are the same as what black women go through.’ They just assumed that... I’m one of them and they can just talk about me however they want [to.]”

“My son passing away... it was announced in the mosque with like 5 000 people. I went ... a week later and I had a swarm around me. There’s no barrier, there’s no boundaries. And I’m a person that grew up in the mosque, loving the mosque. I started disliking going to mosque and ... disconnecting from that... you have to alienate yourself, almost.”

“I don’t need [a therapist] to be Muslim, no, and sometimes... for me to have a Muslim woman [from my culture] might actually shut me up... because I am not practiced in opening up to those people. In fact, the closer you are to me as ... Muslim people [from my culture], the more likely I am to not talk to you because... with my family, you don’t talk about [mental health].”

Shared migration histories and traumas emerged as a specific origin point for this sense of connection as a potential threat rather than as a therapeutic asset. Stoicism and fatalism in Canadian immigrant communities are not specific to Muslim-majority cultural backgrounds, and focus group participants related their personal experiences of these mental health stressors to general histories of migration and conflict as well as to community-specific concerns:

“In the community, or even in a small family, we all know that we’re going through immigration trauma, but no one’s talking about it because it’s like, go, go, go, we’re here and we should be [happy]. It’s expected that the rest of our lives [are] going to be filled with anxiety and trauma.”

“I think the generation, they come from a different place where they’ve just immigrated, they’ve landed in the country, they’ve learned how to survive, and they don’t know how to handle stress... in my family I’ve noticed, especially the elders, they’ve just dealt with it... ‘Just deal with it, just deal with it, you know, I was strong, I didn’t have to deal with anxiety and all that, just deal with it.’”

“the idea of... other people [having] it worse is ... a huge barrier, especially when thinking about the Black Muslim community... the intergenerational trauma of... fleeing a civil war... and then coming to Canada and... most, if not all of the shootings tend to usually be black men, ... so either a friend, a family friend or a family member has been killed, here or back home, or incarcerated or this or that. So that’s happening and *they* bounce back, *they’re* fine, so why do you have to need or require support?”

“[We have] immigrant dads who are just, like no, no tears. You’re not allowed to cry.”

“there’s someone who has it worse than you, ... things are worse back home...”

Service provider experiences also reflected the entanglement of migration experiences and trauma as critical elements in assessing mental health care needs:

“Women who are Muslim at least in my experience and then working with people in the shelter or at the hospital... very often these people who have immigrated recently or have been refugees so its... traumas and challenges associated with those things, might affect their experience...for example the way they interpret psychotic symptoms.”

“They’ve been through difficulties, but what they really need 90% of them, 99% of them need really good settlement services which is key, key to their mental health and well-being and ability to fit in and feel comfortable within a year or two because it’s brutal. It’s the hardest part is settling in a foreign country not knowing a thing.”

“And then the shortcomings in the actual health system are that nobody knows the refugees, the system of refugees. So you know, the week before a refugee hearing, the refugee, anybody is going to be extremely anxious. But if the physician or the system doesn’t understand the context of what it means to be a refugee here like their hearings there are failed hearings, there are you know, appeals at agency, if you don’t understand the system, you can’t contextualise the patient’s symptoms.”

“We live in a marginalized community it can often be harder to seek out help. I think the aspect of it being anonymous non-judgemental I think it really is a draw and a need in the community.”

On their mental health journeys, Muslim women in our sample agreed that they often found themselves in this “limbo” between Western, universalizing models of mental health and care, and experiential models that offer both greater understanding of their particular emotional needs, and the threat of unwanted exposure. Summarized in the next section are the more defensive or avoidant themes explored as a consequence of this limbo, wherein Muslim women anticipate or experience judgment and stigma – both on them and on loved ones and communities – in a variety of contexts that mirror this sense of “in-betweenness.”

Judgment and stigma

In our sample of Muslim women, judgment and stigma were very salient themes in discussing mental health, but had a dual character, experienced and interrogated both where it took the form of discrimination or exclusion in Canadian society – including health-care spaces – or unwelcome judgment from within one’s own community and family. Discrimination, whether faith-based or racial, surfaces in our sample both as a mental health stressor and as a barrier to accessing quality health care, which makes it all the more significant because it tended to arise from ambiguous interactions that Muslim women had to read through an interpretive lens. In the following quote, one participant reflected deeply on the question of whether wearing hijab led to being discriminated against, and how her perception differed from that of her sister:

“I don’t know if I was never smart enough to pay attention and see if my hijab ever got in my way, or am I choosing not to see, and because I’m choosing not to see it, is it translating, and... people are not treating me that way, and is [my sister] being treated that way because she chooses to see it that way, or not?... I really strongly don’t believe what she sees and she really strongly believes what she does.... She’s a lot smarter than I am, she deserves much more than I do, but she doesn’t see it that way and so she kind of keeps herself in a box... Putting [hijab] on for her makes her shrink a bit, in the way she engages with people who aren’t Muslim. She really feels like she is putting a target on her back and I think that becomes this cycle. I think it does influence how people treat her.”

Other participants felt the same pressure to manage the interpretation of others’ behaviour, with impacts on mental well-being:

“After the shooting in Ottawa, a man just turned to me and, his immediate thing was to address the woman next to him about, ‘oh my God, did you hear about what happened in Ottawa?’... why was it that you looked at me? ... my microaggressions are minor instances like that... you feel kind of gas-lighted and... we can’t even address that minor component, how could I talk to [a therapist] about the bigger pieces, issues or challenges?”

“This just occurred to me, I went to a gynaecologist, who is an old white man, but he’s the quickest to accept [new patients], which should be a red flag to anyone... but... he didn’t even look at me for the first ten minutes, and he was going through my ... he’s like, ‘no alcohol, no drugs, no sex’. This is what he did, okay? When he was filling in my forms, he just assumed.”

The double burden of discrimination and of trying to interpret ambiguous, possibly discriminatory experience, is a mental health stressor that one service provider was well aware of:

“I feel like a lot of women don’t necessarily...feel better aware of race based discrimination if it’s happening. I think that there’s the sense...everything’s fine, we’ll manage....there’s a lack of confidence in sort of labeling something as discrimination. So I think just the sheer fact that so many people are seeking out services from a Muslim or South Asian social worker kind of speak to me that they’re feeling it in the other sector, but they don’t necessarily want to label it as that.”

The effects of these types of discriminatory encounters was, for women in our sample, often to condition the kinds of care they felt they could expect and the kinds of care-seeking decisions they felt empowered to make:

“A very big problem that indirectly impacts those kind of [mental health] services that we require is stereotyping and racism, right? And the thing is, the Muslim community is so diverse it’s ridiculous, and no one understands that.”

“Just the fact that we omit certain important truths about our lives. So we just walk into the room [to receive health care]... to me that’s, like, systemic discrimination. Just the fact that, from the get-go I don’t feel safe being in this room, knowing that I need your help to live another day.”

“When I go to therapy I leave my Muslimness at the door, because, you’re never going to understand or be able to support me as a Muslim woman.”

“Things like racism, our response to being racialized, my response to living in poverty, all those things, is a problem that I need to resolve, and it is almost like teaching me coping mechanisms for being racialized. That’s what it feels like. Like, if I’m stressed because I’m dealing with microaggressions at whatever, how are you going to manage that and cope with that. And that’s very useful because I need those skills and I do not have them. But at the same time... it feels like you are teaching people to cope with unfair circumstances. That is how the treatment is delivered here, and I don’t know an alternative.”

At least for one participant, those coping strategies for dealing with discrimination were described as effective:

“When I first came here, I would come in[to an elevator] and be like ‘oh, hi!’; I would find the need to be extra nice to just to [say] ‘Look, Muslims are not bad people.’ Then when I went through therapy, I was like ‘Wait a second, why am I trying to prove that Muslims are nice people? If you’re going to judge me, that’s on you. I’m going to do what I need to do.’ Now when I see someone staring at me, if I want to speak with my accent I make it strong... I take up space.”

In seeking mental health care, our informants also felt they were placed in a position of wanting not to discredit their own family or community or expose them to judgment and misunderstanding, even as they were coping with mental health problems arising in part from their community and family:

“One of the things I notice is that I don’t tell my therapist everything, because I think that I’m going to be judged... There’s things that I purposely leave out. I basically never talk about my family because I know, or I think I know, what she’s going to say about my parents’ influence, about cultural influence. One of my closest friends is a journalist and she did a piece about this a couple of years ago, about mental health in Muslims, and she told me about all the interviews she did with service providers, and it was, like all of my fears were confirmed.”

“I’ve struggled with my faith for most of my life... my therapist and I got to the conversation of the hijab last session... I love to dance, I love to sing, okay?... I could never really do that because if I were wearing a hijab, I can’t go to a place where I’m going to dance [or sing], because now I’m representing other women who wear hijab. I can’t be half here, and half there, it’s unfair to another Muslim woman who may be practicing everything they should be.”

Several of the participants felt they experienced a serious stigma regarding mental health problems from within their family and community, in which certain understandings of spiritual and religious beliefs played a significant role:

“[therapy] has been good or bad, the one thing I pushed off for ... 19 years, accessing anything because of... community stigma... I work in this space and I still have that internal stigma and ... I am a better candidate for antidepressants. I should have been on them for years, but... I don’t like medicine, I’m not supposed to take medicine... so I’ll just talk to someone. That was still me hedging in my treatment. I wasn’t going to dive in fully because culturally, there’s a distrust... in medicine and all that sort of stuff.”

“You expect me to be this person but I can’t be that person because I’ve been raised here... the amount of times that I’ve heard the [term] ‘whitewashed’ in things, like ‘oh, you just don’t understand, you’re not spiritual enough, you’re so whitewashed’... it comes with, I want to say more disappointment than anger, which then adds to my anxiety and my issues.”

“I knew something was wrong... something that I couldn’t control, and I come from a very religious family... if there’s an issue the only solution for it is just... go to the Quran... pray like this and do this... like none of these two things worked. So for me, back then, I was just like ‘all right, there’s nothing that’s going to work then, right?’ If I can’t fix it religiously than something’s wrong with me. ... You would go to university and they’d tell you we have counselling services. They’re the right thing to do... for me I was, ‘no, I’m Muslim... if I go and do this it means there’s something wrong that I did.’”

“What service providers need to understand is the amount of courage... required to come into spaces like that, because if I am seeking this kind of help it’s either [that] you’re just not praying enough, or if it’s... another mental illness like schizophrenia or something like that then there’s so much shame associated with that. ... you’re just not practising enough, or it’s a lack of faith.”

“my dad just ignores the topic [of mental health] but my mother always says to me that ... you’re possessed... meaning black magic, and you should pray more. As far as my faith, I do pray. It is not because of my mental illness, it’s to just feel calm and to feel connected... my eldest cousin... has come out to me and told me that she is suffering from [mental illness] and... my mother’s response was, ‘oh she’s got black magic on her,

pray for her'... I don't know how to handle that, so I just kind of not talk to my parents and my family about these issues anymore."

The problem of community stigma was echoed in many interviews with service providers, who tended to use this lens to a greater degree to frame barriers to care:

"You know, I don't think the issue of mental health in the Muslim community is different from the general population. I think there's a lot of stigma associated with it, people are afraid to come forward, maybe there is heightened awareness ... that is either exacerbated by, you know, cultural nuances in the Muslim community. But I think the biggest challenge, you know, we face in the community is peoples reluctance to talk about it and then being this sense, you know, maybe feel ashamed or feel embarrassed or feel, you know, that they don't know who to turn to."

"Yes there is stigma around that, and...towards people from seeking help...some of them...don't get the help they need cause of the stigma attached to it and...also many times mental health issues...they don't recognize that they have issues and they refuse treatment and they refuse medicine and some other inherent mental issues...they don't want the label they don't want other people to know that they have the mental issues."

For some of the Muslim women in our sample, the differences between older and younger generations in their communities made fulsome conversations about mental health difficult, creating silences and fractures surrounding trauma and other mental health stressors.

In their most regretful or negative reflections, some participants shared that that, being "stuck in the middle" in this way between discrimination and a lack of family and community acceptance, they had internalized an acceptance that they would receive a lower standard of care. However, Muslim women in our sample were also navigating these complexities with varying degrees of success, reflecting on experiences of growing acceptance over time and of positive mental health care experiences – both with and without cultural connections, as well as through nurturing and protective interpretations of spiritual and religious practice.

Caring and acceptance

Focus group participants shared more positive experiences and impressions regarding mental health, and they mostly centred around what makes for good experiences of being cared for, whether in a healthcare services context, among family, or within cultural and religious community. Critical to this was feeling that one was being listened to, and that other people were actively engaged in caring about you. Some of the stories shared under this theme provided a contrast with the feelings expressed under the first theme of culturally-specific knowledge. Shared cultural or religious ties can enhance a caring relationship, but patience and openness could also mark positive caring relationships across difference, if caregivers unlearned the practice of making assumptions, or took a person-centered approach.

"In my case, the services I actually sought, [the practitioner] was not [a] Muslim female. Actually, my cognitive behaviour therapist, he's a male, white doctor. When he actually opened up the session it was about me, like it was focused on me, my health, my problem. And then from there, he sort of went into the background just to find out a little bit of a root cause. He understood the culture, but he also said that it's not only specific to my

culture, and it's not because I'm a Muslim girl and that's why I'm facing it. So I was comfortable.”

“Today I see a registered therapist, ‘registered this’, ‘trained in this’... ‘trained in that.’ If I saw something like ‘trained in some sort of Islamic module’... that meant that any person who can put this on their thing has gone through intensive training that is bias free... Not necessarily lining up every single culture... but teaching them the empathetic skills of being able to relate and accept every person as a different case. Teaching them, ‘how do you approach somebody who doesn't look like your regular patient?’”

Healthcare providers being sensitive and exhibiting caring could also defuse the sense described above that cultural connection could be threatening:

“My family doctor, she's a hijabi. She called me up before she took me on and she said, ‘I don't [break confidentiality].’ It was so unexpected but reassuring. And she doesn't do the [assuming] that non-Muslim doctors do. Every time I go [she asks,] ‘are you sexually-active, drugs, alcohol, smoking, what's up?’ Right? I think her just saying those things to me makes me feel like she's not assuming things about me... They're small things sometimes. That's a good model of the reassurance of confidentiality.

Listening can also make a difference in family and community relationships, sometimes marking a change from stigma to acceptance over a longer period of time. For some participants their mental health experiences became part of a drive to create space for these conversations and to become the person who listens, particularly for younger people in the community:

“Initially, I didn't tell anyone [about therapy] and then when I realized how helpful it was, I started telling everyone. I tell people I meet at the mosque, ‘I go to therapy, it's very normal; it's like when you get the flu and you go to the doctor. When your head doesn't work you go to therapy...’ I want people to know that it's okay, ...so I tell everyone... If we talk about it, that's the only way people will know it's okay.”

“We have blood donation clinics [at the mosque]... why not add in something for mental health? And on the flip-side maybe also train some psychologists and psychiatrists on challenges normally faced by people in [mental health crisis] who [are] actively going to the mosque and want to continue doing that.”

One participant related her four-year journey between her and her mother of accepting the usefulness of therapy. The participant experienced persistent mental distress stemming from trauma and sought care. At first, the participant's mother would deflect expressions of need for mental healthcare, simultaneously identifying the cause and the solution:

“[She would say,] ‘Is this all because you're still not married?... are you reading Quran? Are you praying?’”

The participant described how persistence in not only communicating her point of view but also engaging herself in coaching for Muslim women with mental health needs, helped her mother's perspective broaden:

“Almost four years later, my mom, I think, sees results. She knows that I am a little bit stronger. She can see that I'm happier... she's seeing me... do all of this stuff [and] without really saying it, she gets it. I know that she gets it.”

Participant reflections included descriptions of self-care, and this self-care was often linked to spiritual beliefs and religious practice, with a sense of attention to place and purpose making the difference between practice as mental health promoter or protector, and being a barrier or stressor:

“There is a relation with mental health, and [spiritual practice] does help... sometimes they portray, 'oh, just pray.' No, the purpose behind it should be known. Pray what?... pray for what?... ask for help but ask help for what?”

“Nobody takes time to actually explain to... today's generation, why are you praying? Prayer is not the only thing, like you have to do other things... First do your part, don't just expect help to come down.”

“I do go to the mosque with my kids for a Saturday class... and what I find is that it's very relatable because you learn from that, we human being not only have [mental health] issues, but our prophets and the messengers, they also face a lot of issues... the way they tackled it and everything, so I can relate it to that experience... in [conjunction] with seeing a mental health professional, I would see both [medical and spiritual help]... a white doctor, I won't run away from them.”

DISCUSSION

For many people, expressed in vivid ways by our participants, the quest for the dignity and integrity of the self is marked by wanting to maintain connection to community, spirituality and family but without being trapped in the harmful fatalism resulting from past traumas of migration and oppressive interpretations of culture and religion. One meaning of mental health then for our informants is to achieve an authentic self that is neither assimilated nor repressed. A key finding is that many of these themes overlap with those identified by service providers and spiritual supporters. Stigma within and outside the Muslim community, the need for culturally competent and ethnically diverse care, and patient's desire for validation and understanding were core takeaways from both parts of the study.

Both the service providers and focus group participants spoke about stigma. They mentioned that women face more stigma because of cultural issues. There was a great deal of pressure on a lot of women to put their families first in terms of where to allocate costs, and some noted that they had foregone therapy as they could not justify spending money that could be used for their children or others. They often felt guilt about seeking mental health support, which negatively affected their opportunities to get better. Interestingly, a number of participants expressed openness to more “holistic approaches” and alternative mental health treatments. There seemed to be less stigma around this form of support and more willingness to discuss it with others in the community or in the family.

Cultural competence was also a major issue, with both services providers and patients agreeing that there needs to be effective training around religious and cultural needs. Muslim women noted that they would only feel comfortable speaking to a female therapist, but also that with a non-Muslim therapist, or one of a different ethnicity, there was often a disconnect. They disliked having to explain elements of their culture of family life to a therapist, expecting to speak to someone who was in a position to validate their concerns and offer solutions that they could actually implement within their cultural and family context.

Although service providers are required to provide non-judgmental patient care, the experiences of many interviewees suggest that this does not always happen. Furthermore, many service providers lack an awareness or understanding of the spectrum of religious and cultural practices of their patients, leading to a therapeutic experience that is less than satisfactory or which relies on the patient to educate the service provider on their specific background or to request religious accommodation. Findings suggest that this problem is twofold: there is lack of cultural understanding on the part of many service providers, and there is limited understanding on how to provide religious accommodation, particularly as part of hospital care.

Discrimination due to religion and race was noted more among Muslim women who tried to access care as opposed to service providers, who were more likely to bring up issues of access due to cost and funding constraints. Focus group participants agreed that money was a barrier to access, and often insurance was not enough to cover services. Those who did have insurance were grateful for the access it afforded them.

There were cultural, religious or family stigmas that can prevent a potential patient from accessing much needed mental health care. Addressing these stigmas will involve a concerted effort on the part of service providers, community leaders and individuals.

Another finding discussed external barriers that patients seeking support encountered, this included a high cost of treatment, lack of information on the range of services offered by a provider, or lack of a community based service provider, necessitating patients having to travel far to seek help. There is a clear and urgent need to create more accessibility for these services. Additionally, there is a lack of diverse representation amongst mental health professionals, especially at the community level. The mental health profession in Ontario needs to expand the diversity of its members to include those from diverse religious and ethnic communities, and to enable these members to provide the unique knowledge and community connections that enables service providers to work more effectively.

CONCLUSION

This study explores mental health life narratives of a number of Muslim women living in the Greater Toronto and Hamilton Areas. It sheds light on how well our local mental health services landscape is faring, particularly with regards to accessibility, inclusivity, cultural sensitivity and equity. These conversations can support the future development of tools and resources to enhance service effectiveness. In drawing on the first-hand experiences of those who access services and those who provide services, it aims to develop a better understanding of the capacity of current service providers to offer culturally appropriate, faith-informed services for Muslim women and enhance decision-maker and practitioner understandings of how we can better support this community.

Further research is needed to systematically evaluate current practices within the mental health sector, and to analyze the policies that dictate funding for supports, as well as hiring and training of diverse service providers. In line with the process of this study, research in this area must look at these issues holistically. For example, findings from this study emphasize that culture and religion are not the same, and creating a culturally competent mental health care system requires extensive work and collaboration. Community members and spiritual leaders should play a key role in informing cultural training practices of health professionals, which institutions within the sector must make intentional efforts to increase diversity among therapists and service providers. Additionally, consideration of intersectionality, acknowledging the vast differences in the lived experience of individuals due to a combination of their race, gender, religion and other factors, will help inform effective care.

There is no one-stop shop option for mental health care, and thus providing meaningful, competent support to various diverse communities will require governments, service providers, health professionals and community members to work together to build an inclusive system. We hope that this report will create discussion, support for further research, and help generate recommendations that can improve access to mental health support for Muslim women, and the Muslim community more broadly.

Appendix A: Interview Guide

One-on-one Interviews: Draft Questions

1. Tell me a bit about your role in the mental health sector.
2. Tell me about the service you have provided to Muslim women (or Muslim clients in general) in your practice or organization?
3. How do you understand faith-based discrimination in relation to Muslim women's experiences [offer definition if needed]? How do you think it does or could impact mental health?
4. In your experience, does stigma around mental health relate to the experiences of Muslim women and if so, how? Does a unique or specific form of stigma arise for Muslims or for women in the Muslim community?
5. What, in your experience, are some of the differences you see between Muslim women clients and non-Muslim women clients, in terms of mental health care needs and barriers?
6. What, if your experience, are the sector's shortcomings when serving Muslim clients, particularly Muslim women clients? What improvements or capacity-building efforts would you recommend?
7. In your experience, is faith-based discrimination present in mainstream mental health care?
8. What, if anything, do you need to do your job better when working with this community? Any particular resources, education, information, support, capacity?

Appendix B: Focus Group Guide

Faith-Based Discrimination and Mental Health: Gaps in Service for Muslim Women Seeking Mental Health Care Services

Focus Groups: Draft Questions

Demographic Questionnaire

How old are you? __ 16-24 __ 25-29 __ 30-44 __ 45-59 __ 60+

What city do you live in? _____

Who do you live with (parents, siblings, grandparents, extended family)? _____

Describe your background (racial, ethnic, religious, cultural): _____

Were you born in Canada? Yes / No (circle one)

If not, how long have you lived in Canada? _____

1. Tell me a bit about being a Muslim woman in the GTA.
2. Are you aware of the mental health resources available to you? Can you list a few (2-3)?
3. Have you used any services in the last 5 years? If yes, which ones?
 - a. Are you comfortable using services? Why or why not?
4. Are you comfortable discussing mental health with your family, classmates, colleagues, friends, imam? Why or why not?
5. How do you think disclosing a mental health issue or illness could impact your family life, schooling, or work life? Do you worry about how family, friends or colleagues might react?
6. Do you experience or feel any connection between being a Muslim woman and your mental health (positive or not)?
7. What are some of the circumstances that are affecting your mental health today, if any? (e.g., current or historical trauma, gender, social pressure, school stress, Islamophobia, etc.,
8. Do you think that your identity (racial, ethnic, cultural and/or religious background) influences how other perceive mental health and influences your comfort level in accessing resources?
9. Have you experienced challenges in accessing service? Have you faced any barriers to service and, if so, can you describe these? Are there any reasons you feel these barriers exist?
10. Is there anything that you would like to add or say more about?

Appendix C: Demographic details of participants

Interview	Identify as Muslim/ Non-Muslim/	Gender	Profession	Types of Services provided
1	Muslim	Female	Social Worker, MSW	Private Practice
2	Muslim	Male	Psychiatrist	Community practice
3	Non-Muslim	Female	Psychiatrist	Service people with extreme psychotic disorders for outpatient support
4	Muslim	Male	Psychiatrist	Works within a hospital setting
5	Muslim	Female	Spiritual support	Support service in a Mosque
6	Muslim	Male	Spiritual support	Support service in a Mosque
7	Non-Muslim	Female	Psychiatrist	Service people with extreme psychotic disorders for outpatient support
8	Not recorded	Not recorded	Community support service	Support focused on the Muslim community needs
9	Not recorded	Not recorded	Community support service	Support focused on the Muslim community needs
10	Muslim	Male	Spiritual support	Support service in a Mosque

Focus Group	Age	Location	Identity	With whom do you live?	How long in Canada
1	30-44	Burlington	Muslim, Egyptian	Husband and 3 kids	19 years
1	16-24	Toronto	African-Arab, Muslim	Mother and brother	6 years
1	16-24	Toronto	Somali, Black Muslim	Family	Born in Canada
1	16-24	Newmarket	Persian, Shia	Parents	10 years

1	30-44	Vaughan	Indian-Tanzanian, Muslim	Husband, children	13 years
1	16-24	Toronto	Black, Somali, Muslim	Family (parents & siblings)	Born in Canada
1	16-24	Toronto	Syrian, Tunisian, Arabic, Muslim	Roommate	Born in Canada
2	25-29	Toronto	Afghan, Shia, Muslim	Roommate	22 years
2	30-44	Burlington	Egyptian, Muslim	Alone	24 years
2	30-44	Etobicoke	Pakistani, Kashmiri, Muslim	Sister	24 years
3	16-24	Not recorded	Not recorded	Mother, Brother	Not recorded
3	Not recorded	Mississauga	Not recorded	Husband, children	Not recorded
3	30-44	Toronto	Muslim, Pakistani-Indian/African	Husband	Born in Canada

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About the Canadian Mental Health Association

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province and one territory, CMHA provides advocacy, programs and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.