Experiences, coping styles and mental health of Muslims following 9/11

Cilia van der Ven

Abstract
Following the 9/11 attacks in 2001 and several bombings in European countries such as London, many studies focused on the impact these attacks had on the lives and wellbeing of people in the West. Few studies, however, addressed the consequences of these tragic events for Muslims living in Western countries. The present review describes the impact these attacks had on the lives and mental health of Muslims. Analysis of existing research indicates that many Muslims experienced an increase in hate crimes, discrimination, racism and a loss of community, which all have a profound effect on their mental health. In addition, coping strategies and differences in this area between Muslims and non-Muslims are examined. Findings suggest that positive coping styles are associated with greater post-traumatic growth, whereas negative coping strategies are related to poorer mental health. A better understanding of the problems Muslims face may not only lead to better health outcomes, but it may contribute to more constructive ways of dealing with health issues of Muslims by Western health providers. Implications for mental health professionals and recommendations for future studies are made.

Keywords: Islamophobia, terrorist attacks, discrimination, mental health, coping strategies.

Introduction

The attacks on the Twin Towers in New York in 2001 and several bombings in European countries such as London caused huge commotion all around the world. Many people felt lost, angry and powerless, whereby the latter fuelled the fear for future attacks. The terrorist attacks deepened already existing negative feelings toward Muslims in the West (Barkdull et al., 2011).

After these negative events, Muslims in general were blamed for the attacks and therefore excluded from the public grieving process in many Western countries (Abu-Ras & Abu-Bader, 2008; Mythen, Walklate, & Khan, 2009). In addition of being held responsible, a majority of people who were perceived as being Muslim experienced a tremendous increase in discrimination and racism (Abu-Ras & Abu-Bader, 2008). According to official reports, hate crimes in America against Muslims or people perceived as Arabs increased by a factor of seventeen since 9/11 (Singh, 2002).

While a great deal of research focused on the consequences of these tragic events for Western citizens, few studies have explored the effects of these attacks and the impact of the increase of hate crimes on the wellbeing of the Muslim population. There is growing evidence that experiencing discrimination and racism is associated with negative health outcomes such as depression, anxiety and symptoms of posttraumatic stress disorder (Abu-Ras & Suarez, 2009; Sheridan, 2006).

The results of research by Allen and Nielsen (2002) indicate that one of the best predictors of becoming a victim of discrimination or harassment was being perceived as a Muslim. Having an Arab appearance or wearing specific garments such as a headscarf were most closely associated with such incidents. Many Arab Americans are perceived as Muslims, while a majority of Arabs living in the United States are in fact Christians (Abu-Ras & Abu-Rader, 2008). It is also important to be aware of the fact that Muslims can have various races and ethnicities, since Islam is a religion and not an ethnicity. For instance, in America the three largest ethnic Muslim groups are

Arab Americans, African Americans and South Asians (Abu-Ras & Suarez, 2009).

This review will present a summary of existing research on Muslims in Western countries in the aftermath of 9/11. First, the rise of different forms of discrimination will be explored. Then, the impact of the attacks on the wellbeing of Muslims will be discussed. Subsequently, different coping styles for dealing with stressful experiences following 9/11, and their effects on the psychological health of Muslims, will be considered. Addressing this issue will highlight differences between Western coping styles and non-Western coping strategies, a difference which could have profound implications for the care provided by Western mental health professionals.

Finally, recommendations will be made for both mental health providers working with Muslims and regarding directions for future research.

Rise in Islamophobia

At the beginning of the 1990s the term Islamphobia, which is used to describe an intense fear, dislike or hate of Muslims, emerged for the first time in the United States and Great Britain (Barkdull et al., 2011; Sheridan, 2006). Although this indicates that negative feelings toward Muslims and Islam are not a new phenomenon, the significant post-9/11 rise in frequency of hate crimes shows preexisting interfaith and cross-cultural conflicts between Muslims and non-Muslims have deepened (Fischer, Ai, Aydin, Frey, & Haslam, 2010).

Since 9/11, there have been numerous reported incidents of negative stereotyping, hate crimes and racial discrimination against Muslims (Singh, 2002). The September 11th attacks resulted in a lot of stressful experiences for Muslims living in the United States, including harassment, job discrimination, vandalism of mosques, and special security checks in airports (Abu-Raiya, Pargament, & Mahoney, 2011). Sheridan (2006) found that the majority of British Muslims experienced an increase in religious discrimination, as well as both implicit and overt racism. According to Sheridan (2006), Muslims were most likely to report an increase in incidents of being stared at, hearing offensive remarks and seeing negative stereotypes in the media. These findings support a rise in Islamophobia that was also seen in other European countries following the terrorist attacks in 2001.

Currently, many Americans see Muslims as dangerous people who are untrustworthy, violent by nature, and fanatical in their religious practices (Inhorn & Serour, 2011). All these ideas are stirred up by the media, which makes it particularly hard for Muslims to overcome this stigmatization. Recent research by Barkdull et al. (2011) indicated that the general consensus among Muslim participants from Australia, Argentina, Canada and the United States was that many negative stereotype images and generalizations of Islam and Muslims are seen in the Western media. In the mass media Muslims, especially young males, are often associated with extremism and terrorism, and are rarely presented as contributing positively to society (Mythen et al., 2009).

Furthermore, new immigration policies and anti-terrorist laws made it easier for the American government to monitor, imprison and deport Muslims. As a consequence of increased discrimination and these new strict laws and policies, which particularly target the Muslim population, many Arab Americans feel vulnerable. The US government claims to attempt to promote a sense of stability and security, while the reality is that many Muslims feel threatened by authorities and isolated from the wider community (Abu-Ras & Abu-Badar, 2008).

Nowadays, common concerns among American Muslim men include fears of being deported and of being subject to religious or racial profiling. Muslim women not only face fears of

being harassed for covering their heads, but also have to deal with additional negative stereotypes such as being oppressed by their husbands (Inhorn & Serour, 2011). The effects on the wellbeing of Muslims of not only these fears, but also of the significant rise of different forms of Islamphobia, will be discussed next.

Effects on living and mental health

In a study by Abu-Ras and Abu-Bader (2008) the effects of the 9/11 attacks on the mental health of American Arabs living in New York City were examined. The results showed an increase in worrying about the future, feelings of anxiety and fear of hate crimes, stigmatization and the break-up of Arab American communities, which has led to isolation of its members. In a recent study, Muslims from the United States, Canada and Australia reported more stress following 9/11 (Barkdull et al., 2011). Another study by Rippy and Newman (2006) found a significant association between perceived discrimination and paranoia among American Muslims.

Other studies suggest poorer mental health of the Muslims relative to their non-Muslim peers in Western countries following the attacks. In a study conducted by Abu-Ras and Abu-Bader (2009) many American Arab and Muslim participants scored high on depressive symptoms. Consistent with these findings, research by Sheridan (2006) suggested that more than one-third of their British Muslim participants had high scores on a depression scale, which indicated poor mental health. Variables such as gender, frequency of mosque attendance, and ethnicity did not make any difference in the outcomes. However, the scores were significantly related to reporting a specific discrimination incident and seeing oneself as a highly identifiable Muslim.

Furthermore, the majority of the American Muslim participants researched by Abu-Ras and Suarez (2009) reported post-traumatic stress symptoms such as increased arousal, anger, difficulty sleeping, exhaustion, and problems with concentration and decision-making. Unlike the findings in other studies, however, hate crimes and discrimination were not a predictor of post-traumatic stress symptoms. Only decreased feelings of safety in the United States after the attacks of 9/11 appeared to have a strong relationship with PTSD symptoms. The researchers proposed the possibility that discrimination has different effects on various Muslim populations such as immigrants or religious groups. In addition, some significant differences between men and women in reported symptoms and common fears were discovered. Men more often expressed feelings of fatigue and exhaustion and fear of increased harassment by the government, whereas women were more likely to report a reluctance to leave home, and a greater fear of being in public places (Abu-Ras & Suarez, 2009).

Unfortunately, there is a lack of imams and mental health professionals who could provide Muslims with the kind of treatment that will enable them to effectively deal with these health issues and fears (Barkdull et al., 2011). In recent years, the increased stress in the lives of Muslims has led to an increase in appeals to imams for counseling. Unfortunately, these religious leaders often do not have the mental health training needed to effectively deal with these requests (Inhorn & Serour, 2011). Furthermore, Muslim community institutions were widely viewed by the American public as seedbeds of terrorism and therefore had to close their doors. In addition, 9/11 also raised suspicions within the Muslim community itself. This resulted in a loss of peer support and a feeling of not belonging to a wider community. Traditionally, the community plays an important role in supporting Muslims in many different ways, such as providing emotional support and forming a crucial link between government authorities and Muslims (Abu-

Ras & Abu-Bader, 2008). This made it even more difficult for Muslims to express their distress. In addition to inadequate care inside their own community, the 9/11 attacks made it harder for Muslims living in the United States to find and receive medical care outside their community that is in accordance with their religious norms and values (Inhorn & Serour, 2011). The next section of this paper will focus on the ways that Muslims have coped with the kinds of stressful experiences they have endured since 9/11.

Coping strategies

Following the 9/11 attacks, Muslims responded in various ways to the increased Islamophobia with which they were confronted. The increased negative experiences have led to an increase in religious practices such as praying, reading religious writings, fasting and mosque attendance (Abu-Raiya et al., 2011)**.** Many Muslims reported tolerance, forgiveness of others, and faith as their coping strategies to deal with this rise of Islamophobia (Abu-Ras & Abu-Bader, 2008). Some Muslims instead asserted their Muslim identity by wearing specific clothes. Others engaged in interfaith dialogues, used the media to teach the public about Islam, or increased their political engagement (Barkdull et al., 2011).

There has recently been increased research positing a relationship between responses of Muslims post-9/11 and their wellbeing. This relationship was explored by, among others, Abu-Raiya et al. (2011), who not only indicated that Muslims applied both religious and non-religious coping strategies to handle post-9/11 stress, but that these strategies also had a profound effect on their mental health. In their study, two important non-religious coping methods, namely reaching out and isolation, were found. In the first strategy, people in distress reached out to others for comfort, educated others about their religion, and joined groups engaged in interfaith dialogues. This coping style was associated with more post-traumatic growth after 2001. However, Muslims who applied the latter strategy isolated themselves from other Muslims and non-Muslims. Isolation not only predicted higher levels of anger, but also significantly higher levels of depression.

Subsequently, Abu-Raiya et al. (2011) argued that religious coping methods play an important role in the lives of Muslims. Positive religious coping styles such as a belief in a transcendent meaning, spiritual connectedness with others, and a good relationship with Allah were related to greater post-traumatic growth. On the other hand, negative religious coping methods like expressions of a less secure relationship with Allah, a religious struggle to find meaning in life, and the idea that the world is a dangerous place were all associated with higher levels of depression. In line with these findings, prayer, forgiveness, tolerance and educating non-Muslim Americans about Islamic culture were seen as positive coping strategies in research by Abu-Ras and Abu-Bader (2008).

The results of these various studies suggest that the coping styles Muslims use have a profound impact on their overall mental health. An essential addition to these findings is provided by Fischer et al. (2010). They point to the fact that most research has focused on Western individual-oriented coping methods, while not much is known about the collective-based coping strategies of other cultures such as the preferred coping styles of the Muslim population. Their research indicated that Muslims tend to choose interpersonal, collective-oriented coping styles. The importance of Islam, and of belonging to a religious Islamic community, have contributed to a strong religious identity among Muslims, and this in turn has shaped the way Muslims cope with stress and suffering. According to Fischer et al. (2010), the traditional Western view of individual-oriented coping styles disregards the importance of

social ties, religious community and family decision-making processes in the area of clinical counseling. In the following section, implications of these findings for health providers are discussed.

Implications of research findings

Recent findings indicated that there are profound differences between the interpersonal, collective-based coping styles of Muslims and Western individual-oriented strategies (Fischer et al., 2010). The implication of these differences is that psychology rooted in Western notions of mental health does not seem to provide mental health professionals with effective principles for treating Muslim clients, because (among other reasons) such notions disregard the importance of family and religious community ties (Fischer et al., 2010).

Therefore, mental health professionals need to be particularly sensitive to these socially based coping styles and the consequences they may have for the ways Muslims choose to deal with distress. Integrating collective coping styles into clinical treatment may be a dramatic step forward in helping Muslim clients (Fischer et al., 2010). Furthermore, mental health professionals should embark upon the important task of encouraging Muslims to apply positive coping strategies such as reaching out to others and finding a greater meaning, which may lead to better health outcomes (Abu-Raiya et al., 2011).

Additionally, Inhorn and Serour (2011) emphasized the major role that religious community leaders play in the physical and mental health issues of Muslims. Some Muslims will seek the opinion of a religious leader about their medical treatment before they will agree to a specific intervention. The permission of this authority is an important part of the treatment that should not be underestimated by Western health professionals. Thus, if health-care clinics work together with religious institutions, the outcomes for many Muslims might improve (Inhorn & Serour, 2011).

As discussed earlier, the attacks also resulted in a loss of community support and isolation, while social ties usually are extremely important among Muslims for handling stressful life experiences and health issues (Abu-Ras & Abu-Bader, 2008). Besides counteracting this isolation, health providers should also acknowledge the wider problems felt by Muslims such as discrimination, harassment, problems of stigmatization and job loss (Barkdull et al., 2011). Because of the extent of these problems, political initiatives and broader educational programs for the general public are also needed.

Conclusion

This review explored existing research about the impact of the 9/11 attacks and several bombings in European countries on the wellbeing of Muslims living in the West. Analysis of these studies indicated that Muslims not only were held responsible, but also experienced a tremendous increase in hate crimes, discrimination and racism (Abu-Ras & Abu-Bader, 2008; Singh, 2002). This rise in Islamophobia significantly increased the stress in the lives of Muslims, which had profound effects on their wellbeing (Barkdull et al., 2011). Research indicated that many Muslims showed increased signs of depression, anxiety, paranoia and post-traumatic stress symptoms (Abus-Ras & Abu-Bader, 2009; Abu-Ras & Suarez, 2009; Rippy & Newman, 2006; Sheridan, 2006).

Following the attacks, Muslims used various religious and non-religious coping strategies to deal with the increased stress, strategies which were associated with different health outcomes (Abu-Raiya et al., 2011; Abu-Ras & Abu-Bader, 2008). An important contribution to these findings was made by Fischer et al. (2010), who emphasized the importance of acknowledging differences between

Western individual-oriented coping styles and the interpersonal, collective based coping styles of Muslims. If these differences are integrated into the clinical setting, and if mental health providers are more sensitive to the serious problems Muslims face (e.g., discrimination and isolation) better mental health outcomes for Muslims in Western countries may result (Abu-Ras & Abu-Bader, 2008; Barkdull et al., 2011).

The analysis of existing research also revealed some limitations. Many studies used health scales designed for Western populations, whereas it is known from previous studies that mental illness is often expressed within non-Western cultures through physical complaints (Abu-Ras & Abu-Bader, 2008). This assessment method may thus have resulted in an underestimation of Muslim mental health issues. Another problem researchers face in drawing conclusions is the fact that there is a lack of pre-9/11 measurement to serve as baseline. This means that most of the research in this area is retrospective by nature, which makes it especially hard, if not impossible, to draw causal inferences.

Furthermore, this present review mainly cited research that focused on the psychological processes that were triggered by the attacks. Exploring research conducted by different disciplines could also make significant contributions. The discipline of sociology, for instance, considers broader issues such as social structure, social class and social institutions (Aronson, Wilson, & Akert, 2010). Being less interested in the psychology of the individual, this discipline is concerned with the bigger picture of society. In exploring the impact of the 9/11 attacks, sociology focuses on different questions.

This latter type of research would explore various important questions, such as why a society or a particular group within a society tends to have different outcomes (Aronson et al., 2010). This means that sociology among other things is concerned with questions about the relationship between possible structural differences among various ethnic populations of Muslims, on the one hand, and mental health outcomes, on the other. Thus far, not enough studies address differences among Muslims. It has been previously said that “the Muslim” does not exist. It is possible discrimination has different effects on various populations of Muslims (Abu-Ras & Suarez, 2009). It could be that there are differences among, for instance, Arab American, South Asian and African American Muslims.

Another topic of interest for sociology might have to do with the way the larger society influences behavior. Research indicated that there are sometimes profound differences in the experiences of Muslims in different Western countries (Barkdull et al., 2011). Why did Muslims in Argentina have different experiences pre- and post-9/11 than Muslims living in America, Canada and Australia? The scope of these questions reveals the important contribution sociology could make to this line of research.

Concluding, it is evident that further research on this topic is needed. Although the present review showed that a good deal of research has been conducted regarding the impact of the 9/11 attacks on the lives of Muslims, much is still unknown. It may well be that outcomes differ depending on demographic variables such as race, gender, education, income and immigrant status. Few studies explore differences between men and women, although research does suggest there may be significantly different outcomes in reported symptoms and fears (Abu-Ras & Suarez, 2009). Besides, in many studies to date participants are well educated and have a relatively high income. Therefore, future research is needed on both the impact the attacks had on the lives of less successful Muslims (e.g., new immigrants) and on gender differences. Finally, integrating research results of different

disciplines such as psychology and sociology could further expand the knowledge in this field. This could in turn lead to highly targeted effective interventions for Muslims requiring mental health services.

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