# Insights into the Psychological Sequelae of Spiritual Abuse

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## Abstract

Spiritual abuse has been defined as the misuse of authority by a religious leader in order to coerce or manipulate community members for personal gain. Spiritual abuse can encompass financial gain, sexual misconduct, or harassment/bullying. In this paper, we present a case of a teenage Muslim girl abused at the hands of her local mosque's Imam that exemplifies the sexual misconduct sub-type of spiritual abuse. The Patient, already a victim of childhood trauma, was groomed by the Imam starting from the age of 13 until he engaged in sexual relations with her at the age of 18- after which he immediately revoked his previous promises of marrying her. The Patient subsequently suffered severe psychiatric, social, emotional and spiritual distress due to her trauma history and emotional attachment to the Imam. The reactions of a victim suffering from spiritual abuse may seem counterintuitive to those not familiar with the psychological impact of trauma and abuse. As such, it is important to further elucidate the psychological state of a victim suffering from spiritual abuse.

In this paper, we aim to explain the series of psychological impacts of spiritual abuse including grooming, moral confusion, nonresistance to prolonged abuse and failure to report. We also aim to elucidate the complex layers of vulnerabilities victims, such as this Patient, experience that may hamper their ability to identify red flags and remove themselves from harm. Additionally, a variety of social, cultural and religious factors inherent in Muslim populations can unintentionally enable spiritual abuse. The Catholic church has long been criticized for their poor handling of sexual abuse scandals. The criticism, however, has led to extensive study into the barriers and biases which can overcome a religious community from effective response to abuse cases. By utilizing these extensive studies and drawing parallels from abuse studies in Muslim populations, we can better understand how spiritual abuse occurs and what interventions to equip the Muslim community with to ensure appropriate response.

**Case Study**

At the time of this case study, the Patient was an 18 year old, Muslim, single, female with no known medical history. The Patient had a reported past psychiatric history of trauma sustained in childhood stemming from being abused by her father. Upon her parents' separation, she additionally suffered from related abandonment issues. Due to these psychological issues, the Patient's mother sought counseling for her from the Imam of the local mosque. The Imam would see her very frequently and eventually developed a relationship beyond what is typical of a counseling-patient relationship. For example, the Imam cosigned the Patient's car loan and loaned her money for a laptop. The Patient regarded the Imam as a father figure, often even endearingly referred to him as "Baba" (father).

The Patient was counseled by the Imam from the ages of 13 to 18. At 18, she sought assistance from the Imam to help find her a suitable husband. The Imam, who already had two wives, replied stating he "still had a few spots available." Later that night, the Imam called her and formally stated his interest in marrying her. While the Patient accepted his proposal, this began a year-long "grooming" process. The Imam and the Patient communicated over phone, text, and video calls. The Imam was methodical and manipulative in slowly nudging the conversations along increasingly sexual lines. If the Patient complied with the explicit nature of the conversations, the Imam would be content. However, if the Patient refused to comply, the Imam would immediately cease contact with her. This act would target the Patient's emotional dependence on the Imam, as well as trigger her childhood abandonment issues. Eventually, she would find herself so emotionally distraught where she would find no resolve other than to comply with his graphic demands. Demands of this nature included sexual texts, pictures in lingerie, and belly dancing and undressing on video chat. Eventually after a year of inching along these lines, the Imam sent the Patient an address to a Motel 6. Initially, the Patient was unaware the location was a Motel. When the Patient realized the location, she assumed they were simply going to talk. When she arrived at the room, the Imam came out of the bathroom naked and performed sexual acts on her. Immediately afterwards, he told her it that he would never see her again, revealing he had no intention to marry her at all.

After the Imam cut complete ties with the Patient, she was extremely distraught. The Patient was reported to have become severely depressed, having suicidal ideations, and weight loss. After revealing the sexual acts to her parents, they kicked her out of their home. The Patient was reported to have been living on the streets at this time. The Patient went on to report the acts to a director of the mosque, who advised her to seek mental health counseling but discouraged her from speaking out about the matter because it would ruin the Imam's reputation as a religious leader and a family man. The Patient then went to other members of the board who confronted the Imam. The Imam denied these claims, but he resigned the day after. Importantly, upon the Imam's resignation, the board did not publicly reveal the reason for the Imam's resignation. Instead, the board publicly thanked him for his years of service. It was not until the Patient hired an attorney that the cause of the resignation was publicly released by the board. In July 2019, the Imam was tried and found guilty of sexual misconduct against the Patient and was charged $2.5 million in damages due to sexual exploitation, clergy malpractice, and grooming (Salem, 2019).

## Background

### *Spiritual Abuse*

The aforementioned case is representative of a broad phenomenon known as spiritual abuse. Spiritual abuse is when a religious leader misuses authority to coerce or manipulate community members for personal gain. The term can encompass financial gain, sexual misconduct, or harassment/bullying. This case involved spiritual abuse of the sexual misconduct sub-type (Qasim, 2017).

### *Patterns and Psychological Effects of Spiritual Abuse*

Studies of firsthand accounts of clergy sexual misconduct in the Catholic faith describe a characteristic pattern of abuse (Garland & Argueta, 2010). The first hint of misconduct arises in a process known as "grooming," when the religious leader targets his or her prey and deliberately makes slow advances to develop a closer relationship. Advances can be in the form of complements, displays of affection, concern, or slight touches and are often masked in religious framework. For example, in one instance a clergy member told his victim that they "are the answer to their prayers" (Garland & Argueta, 2010).

In order to appreciate how spiritual abuse occurs, one must have an understanding of the powerful conscious and subconscious effects a religious leader can have on his or her congregants. Often, the spiritual leader is seen as being astutely wise from decade's worth of sacred study, and respected for playing the important role of deciphering God's message for the congregation's understanding. Every week, the leader charismatically delivers sermons that move and fascinate the masses. This inherent role of a spiritual leader often leaves loyal congregants full of wondrous awe, heartfelt respect, and even an intimidating fear of disappointing their honored leader. These overwhelming emotions can lead to a phenomenon known as "religious duress" (Benkert & Doyle, 2009). From a psychological perspective, religious duress is an incapacitating fear which impedes a victim's ability to accurately process and recognize seductive "red-flag" patterns in the grooming process. Victims often second-guess themselves and lean towards giving the religious leader the benefit of the doubt. Due to this uncertainty, the religious leader is allowed to cross more significant boundaries which, by this point, may have likely produced alarm in a layman. Boundary violation is considered to be a precursor of spiritual abuse. In this manipulated state, the victim may at first even enjoy the personal attention he or she is being given by a figure of such high regard. However, victims simultaneously experience guilt and fear in finding difficulty restoring boundaries to their previous state (Garland & Argueta, 2010).

Grooming is often a slow but deliberate process where a predator violates boundary by boundary until his or her destination is reached. When outright sexual abuse finally occurs, victims report being paralyzed with fear and disbelief. This often leads to the next psychological impact of abuse known as "moral confusion" where victims struggle to understand the overwhelming and disturbing paradox of a holy figure partaking in sin (Benkert & Doyle, 2009). Adolescent-aged

victims have been observed to experience severe feelings of guilt, even blaming themselves for leading a clergy member to sin (Benkert & Doyle, 2009).

Frequently, the abuse continues to occur as victims are impacted by "moral confusion", which causes skeptics to criticize and question why the victim continued to, seemingly willingly, return to their abuser. This phenomenon can be explained by understanding the neuropsychological and physiological implications of chronic abuse. Developmental neurobiology studies have shown that the chronic stress of being exposed to fearful stimuli can have harmful effects on the hippocampus, left cerebral cortex and the cerebellar vermis. These brain structures have crucial roles in helping to appropriately integrate sensory input in order to assist the limbic system, midbrain, and brain stem in appropriately responding to fear and danger (Teicher, et al. 2002). Simply put, victims of chronic abuse cannot be expected to have the same response as a neurotypical person of similar background who has not experienced chronic abuse. Furthermore, in the state of suffering chronic abuse, victims report feeling trapped and utterly powerless to stop the abuse. For this reason, the ability to provide "meaningful consent" in the moment of abuse is also hampered by the disrupted neural pathways and cannot be expected from a victim of chronic abuse in the same manner as someone who has not experienced abuse.

Additionally, the secrecy that surrounds spiritual abuse creates uncertainty and yet another opportunity for the abuser's manipulation. For example, in the case above, the Patient, suffering from deep shame and guilt, was easily convinced by her community's beloved religious leader that no one would believe her claims against him. As is also true of the Patient, the social isolation which follows for such victims can lead to an even deeper attachment to the abuser where a phenomenon known as a "trauma bond" may develop (Foote, 1998). Trauma bond, similar to the Stockholm Syndrome, is when the victim experiences a profound emotional attachment to their all-powerful abuser, and believes they have no other choice but to remain in the abusive relationship (Foote, 1998). The bond becomes stronger and increasingly pathological as the relationship continues. Pathology may be additionally complicated with the pre-existing emotional relationship with the religious leader and any previous psychological history (Benkart & Doyle, 2009). Thus, there may be several underlying issues that can each serve as a barrier preventing a spiritual abuse victim from breaking free of the abuser.

## *Cultural Barriers for Reporting Sexual Abuse in Muslim Populations*

Interestingly, studies of women leaving abusive relationships in American and Arab populations, for example, reveal a stark difference between one another. Studies conducted in American populations primarily examine the internal processes battered women experience (Landenburger, 1993; Phillips, 2001). Whereas studies in Arab populations focus on external sociocultural factors that impede a woman's decision to leave her abuser. (Al-Krenawi & Graham, 1998; Cohen & Savaya, 1997; Haj-Yahia, 2000; Phillips, 2001). Sociocultural factors such as the 'group-oriented' culture of Arab societies instill values that subordinate an individual woman's trauma to the more valued protection of the family unit. Women are expected to uphold the reputation of the family by staying loyal to them. A large proportion of the Arab community is observed to blame a divorced battered woman, labeling her as damaged, loose, and rebellious, all while not holding her violent husband responsible. As a result, in order to avoid violating social

norms and being outcasted, abused Arab women have historically been observed to suffer prolonged severe abuse (Phillips, 2001).

Enduring psychological suffering in the face of being shunned is also evident in the population of sexually abused South Asian children. Nationwide child sexual exploitation and grooming reports in the United Kingdom revealed the abuse of South Asian girls is rarely reported due to the fear of being ostracized by their community (Committee Office, and House of Commons, 2013-14). In South Asian culture, "honor" is a crucial dynamic. Women are often regarded as physical personifications of family honor, where any misbehavior can bring about tremendous shame to the family. Shame and dishonor in the South-Asian community can produce drastic changes that influence the marriageability of the abused woman and her close family relatives. In qualitative interviews, South Asian sexual abuse victims cite the struggle to maintain family honor and avoid 'sharam' (shame) as a crucial factor that prevents them from speaking out about their sexual violence (Cowbell, Gill, & Harrison, 2015). Another inhibiting factor in South Asian culture is the cultural modesty that envelopes and inhibits the discussion of anything remotely sexual. These inhibitions produce a barrier from parents having conversations that provide children protection by giving them an awareness of what behaviors constitute sexual abuse. Additionally, it prevents children from reporting their abuse to their parents due to the discomfort and embarrassing nature of the taboo conversation (Cowbell, Gill, & Harrison, 2015).

*Barriers to Treatment*

Factors inherent in the cultures of Muslim populations not only inhibit the reporting of sexual abuse but can also affect seeking out mental health treatment as well. Studies have shown that Muslim Arab-Americans are six times less likely to attend therapy in their lifetime as compared to Christian Americans (Levy et al. 2012). Stigma is a significant factor of Muslim Arab-American and South Asian cultures that can inhibit the likelihood of seeking mental health treatment. The stigma of mental health is deeply embedded in many Muslim cultures, as seen in supernatural and traditional explanations for mental health issues. Psychiatric symptoms are often seen as a result of possession of Jinn, sorcery, evil eye or punishment from Allah for previous sinning (Weatherhead & Daiches, 2010; Youssef & Deane, 2006). For example, patients who exhibit depressive symptoms are believed to have a poor connection with God (Alhomaizi et. Al, 2017). These deeply held beliefs often result in avoiding professional mental health care and only seeking alternative treatment via spiritual healing or non-psychiatric medical treatment due to a tendency to somaticize mental health issues (Okasha, & Okasha, 1999; Smith, 2011).

While the stigmatization of mental health occurs in many communities, the Arab community's collectivist nature and strong religious views provides an example of amplified stigma. In qualitative sociological interviews of the Muslim Arab-American community, participants stated that community members dealing with mental health crises often became the subject of gossip and harsh judgment. Community members criticized and labeled their fellow community members suffering from mental health issues as "abnormal, weak, lazy, and dangerous to be associated with" (Alhomaizi et. Al, 2017). For these sufferers of mental health, the awareness of their culture's negative beliefs can stimulate an internalization and acceptance of these views known as "self-stigma". For example, a patient raised in a society that criticizes people battling

clinical depression as lazy or weak may begin to accept this and see themselves as such. Studies have shown a link between the effects of self-stigma and a state of hopelessness, known as the "why-try" effect. In this state, the patient exhibits diminished goals, failure to pursue opportunities, and effective treatment (Corrigan et. Al, 2009).

Studies have revealed an additional barrier towards Muslims seeking treatment exists in their mistrust of mental healthcare professionals. Surprisingly, this can exist regardless of whether the clinician is Muslim or Non-Muslim. When the clinician is Non-Muslim, the Muslim patient may fear that the mental health professional will not be able to understand Muslim values. The concern is that this lack of understanding might lead to the provider to encourage non-Islamic values that normalize dating, engaging in sexual activity outside the bonds of marriage, and drug-use. On the other hand, a clinician who is Muslim may produce a fear of being judged for engaging in misbehavior or a breach of confidentiality that could lead to gossip about one's private information throughout the community (Alhomaizi et. Al, 2017).

**Discussion**

When a patient seeks mental-health counseling, they are often in the most vulnerable state of their lives, desperately seeking help. Often, the Muslim who is suffering from psychiatric issues has an unconventional route to seek counseling. As discussed, this could be due to a variety of factors such as mental health stigma or even being unaware that mental health services exist at all (Alhomaizi et. Al, 2017). Consequently, the Imam often becomes the community's first-responder in whom the distressed Muslim confides. The Imam's role as a first responder includes the ability to assess if the approaching party requires a referral to a mental health professional. However, the distressed Muslim navigating this route is left vulnerable to a predatorial spiritual abuser. The responding religious leader holds a tremendous responsibility to provide a safe space for their suffering congregants with clear-cut boundaries of the patient-counselor relationship. Providing money for personal items or co-signing automobile loans, are some ways the Imam in our case study crossed the boundaries of the typical patient-counselor relationship. By crossing such lines, especially when counseling a patient with a history of paternal abandonment issues, the Imam created a dangerous level of emotional attachment from the Patient. The actions taken by the Imam were likely methodical, however, the critical point is that the emotional attachment and vulnerability of the Patient interfered with her ability to give meaningful consent to the Imam's sexual advances (Salem, 2018).

The role of women in Muslim societies includes being a personification of their family's respect and honor. Young women are under tremendous pressure to avoid situations that could put their family's 'izzat' (respect) at risk. Simultaneously, the culture's misappropriated value of modesty inhibits the discussion of sexual topics, that can help prepare young women for the recognition of abusive patterns (Cowbell, Gill, & Harrison, 2015). When "boundary crossings" inevitably arise, a young Muslim woman shaped by these incorrect cultural beliefs may be unprepared to handle the trespasses effectively (Benkart & Doyle, 2009). Each boundary crossing by a manipulative abuser can produce a severe level of shame and negatively impact a young Muslim woman's

self-esteem and warp her sense of dignity. These negative emotions can cause her to isolate herself and further strengthen the dependence on her abuser.

The grooming process utilized by the Imam in this case utilized slow but consistent boundary crossing with his sexual requests. When the Patient attempted to refuse sexual requests, the Imam leveraged her emotional dependence on him by entirely ceasing all conversation with her. Having to choose between reliving the psychological trauma that stemmed from the abandonment of a fatherly figure or feeling great shame in violating her religious morals, the Patient was in a constant lose-lose battle of severe emotional distress. Additionally, in committing acts that are religiously taught to only to be done with one's husband, the Patient's attachment grew even more pathologically. Having trusted the Imam on so many levels and in other domains of her life, the Patient may have earnestly trusted the Imam's marriage proposal and believed that the relationship was headed in the right direction, only to find out that he never had any intention to marry her at all. Hence, Muslims seeking counseling from Imams are not only vulnerable in their current distressed state, but may also arrive with socially, religiously, and psychologically impacted vulnerabilities as well.

Most importantly, the discussion of this case highlights the enormous depth and complexity of a victim's experience of traumatic abuse. It is also essential to examine communal factors the abuser capitalizes on to be successful in his or her abuse. The clerical culture fosters strong emotions of awe and fear, creating religious duress in the victim, the victim's parents, and congregants (Garland & Argueta, 2010). Just as the religious leader grooms his or her victim not to disclose the abuse, the leader additionally grooms the victim's family members not to believe the victim if they report their abuse. The wondrous awe that surrounds the abuser as he or she charismatically leads the congregation can create a cultural environment where the leader's supporters hear abuse allegations and fervently protest, "he/she would/could never do such a thing." As a result, the victim may go on to develop psychological, legal, and substance abuse issues as a consequence of sustaining chronic and long-term abuse. Community members often do not understand these issues as sequelae of abuse, but rather inappropriately judge them at face value. At this stage, the 'accused' is a religious symbol of purity. The 'alleged' community member takes on the symbol of deceit. Thus, in the public stage, when the victim of spiritual abuse comes forward with the allegation it can quickly develop into a battle between a nearly-universally loved symbol of piety versus the community's 'problem child' (Ajami & Qasim, 2017).

Not only do predators become masters in manipulating their superior credibility over their victim, but are additionally empowered by the poor handling of abuse cases in the Muslim community. After the Patient's case surfaced, investigators discovered it was actually the Imam's third known abuse case. Both of his prior cases also involved an inappropriate relationship with a female congregant with false promises of a marriage. In both cases, the Mosque also terminated the Imam but kept the reasons for his termination confidential. The Imam was easily able to find employment at another Mosque that was unaware of his predatory tendencies. Of importance, the second case was kept confidential at the request of the family of the victim. The family feared that disclosure would lead to the revelation of the victim's identity, which would inevitably damage her reputation in the Muslim community. The family continues to decline to speak of the abuse, to this day, in fear that it would endanger the victim's relationship with her spouse

(Salem, 2018). 'Izaat' is again observed to be a dominant driver of decision making in many Muslim communities. Similarly, in our case, the Patient initially approached a mosque board member with the allegations who discouraged her from releasing the information due to the damage it would cause on the abuser's reputation (Salem, 2018).

In scrutinizing the details of this case, we have examined many barriers of Muslim populations to respond to spiritual abuse cases. However, despite all of these obstacles, the case was allowed to be reported, treated, publicized, and result in a successful trial. Thus, we can also examine factors that lead to these positive outcomes in order to guide Muslim communities to recognize and respond to spiritual abuse cases effectively.

The effects of suffering a traumatic experience at the hands of a religious leader have not only been observed to result in psychological dysfunction but, additionally, result in spiritual consequences as well. Victims report a disruption in their relationship with God and often abandon their spiritual beliefs altogether. This is particularly concerning considering that sexual abuse victims report religion and spirituality as potent coping mechanisms (Falsetti, Resick, & Davis, 2003; Kennedy, Davis, & Taylor, 1998;Glòria, Littlewood, & Leavey, 2013). In a study on nuns who were sexually abused by priests, the integration of their trauma into a religious narrative provided positive outcomes and eventual posttraumatic spiritual growth (Glòria, Littlewood, & Leavey, 2013). It may be extremely difficult to overcome the negative perceptions a spiritual abuse victim has associated with religion, but community support can help drastically (Kozak, 2019). The abused nuns described that a significant positive factor in their treatment was community acceptance and public support. The acceptance, love, and support of community members was a legitimizing and healing experience for abuse victims (Glòria, Littlewood, & Leavey, 2013). Furthermore, a community's perception of mental health has a congruent and robust effect on the treatment of its community members (Alhomaizi et. Al, 2017). When family or community members encourage and praise an individual for seeking treatment, the patient is seen to be more likely to continue treatment. Therefore, it is essential to create a safe space in the Muslim community for its members who suffer from the entire spectrum mental health issues, including the psychological sequalae of spiritual abuse.

What exactly does a safe space in the Muslim community look like? In our case, a community activist reached out to support the Patient once the Patient disclosed her abuse. The activist referred the victim to an attorney and a professional victim's advocate. The two professionals corresponded with the mosque's board members to ensure the just handling of the abuse case. Had it not been for their correspondence, the mosque board would have allowed the Imam to once again resign confidentially, likely resulting in finding employment at yet another mosque, and inevitably perpetuating the cycle of abuse.

The competent referral to the appropriate professional, for the desired outcome, at the right time is crucial in moving forward with an abuse case. For example, if a victim is at the point where he or she seeks restorative justice, they require a referral to a legal professional in addition to a mental health professional for psychological trauma. At times, the victim may only be ready to address either the legal or psychological aspects of their case at a time. Most religious communities are unprepared in addressing abuse cases as they arise (Qasim, 2017). Being prepared prior to an acute crisis can include already having in place a crisis response team of

appropriate professional contacts, protocols, and access to spiritual abuse toolkits. Other aspects of community preparedness includes: preventative spiritual abuse awareness trainings to teach healthy boundaries, workshops to promote recognition of the signs of spiritual abuse as early as possible, lectures and sermons to educate community members on open communication about the various forms of abuse and how to protect oneself, community dialogues to open avenues for safe disclosure, professional or peer-led support groups to provide support for victims, and establishing a trustworthy checks and balances system within the religious leadership hierarchy to ensure the building of a safe community.

**References**


1. Ajami, Juhayna, and Danish Qasim. "Psychologist Dr. Ajami: The Need for Safe Spaces for Victims." inshaykhsclothing.com/ psychologist-dr-ajami-the-need-for-safe-spaces-for-victims/.
2. Alhomaizi, Dalal, et al. "An Exploration of the Help-Seeking Behaviors of Arab-Muslims Living in the US: A Socioecological Model." *Journal of Muslim Mental Health* 11.1 (2017).
3. Benkert, Marianne, and Thomas P. Doyle. "Clericalism, religious duress and its psychological impact on victims of clergy sexual abuse." *Pastoral Psychology* 58.3 (2009): 223-238.
4. Committee Office, and House of Commons. " Home Affairs Committee - Second Report Child Sexual Exploitation and the Response to Localised Grooming." *House of Commons - Child Sexual Exploitation and the Response to Localised Grooming - Home Affairs Committee*, 2013,publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/6802.htm.
5. Cowburn, Malcolm, Aisha K. Gill, and Karen Harrison. "Speaking about sexual abuse in British South Asian communities: offenders, victims and the challenges of shame and reintegration." *Journal of sexual aggression* 21.1 (2015): 4-15.
6. Durà-Vilà, Glòria, Roland Littlewood, and Gerard Leavey. "Integration of sexual trauma in a religious narrative: Transformation, resolution and growth among contemplative nuns." *Transcultural psychiatry* 50.1 (2013): 21-46.
7. Falsetti, Sherry A., Patricia A. Resick, and Joanne L. Davis. "Changes in religious beliefs following trauma." *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies* 16.4 (2003): 391-398
8. Foote, W. "Affidavit." *Does I, II, III vs. Catholic Diocese of El Paso, Father Irving Klister* (1998).
9. Garland, Diana R., and Christen Argueta. "How clergy sexual misconduct happens: A qualitative study of first-hand accounts." *Social Work & Christianity* 37.1 (2010): 1-27
10. Hassouneh-Phillips, Dena. "American Muslim women's experiences of leaving abusive relationships." *Health Care for Women International* 22.4 (2001): 415-432.
11. Kennedy, James E., Robert C. Davis, and Bruce G. Taylor. "Changes in spirituality and well-being among victims of sexual assault." *Journal for the Scientific Study of Religion*(1998): 322-328.
12. Kozak, Janet. "What No One Told You about Spiritual Abuse in Islam: Page 2 of 2." *About Islam*, 5 Jan. 2019, aboutislam.net/family-life/your-society/no-one-told-spiritual-abuse-islam/2/.

13. Levy, K. N., et al. "Differential use of psychotherapy treatment by young adults as a function of sex, ethnicity, religion, and adult attachment style." *Manuscript in preparation* (2012).
14. Okasha, A., and T. Okasha. "Somatoform Disorders—An Arab Perspective." *Somatoform Disorders*. Springer, Tokyo, 1999. 38-46.
15. Qasim, Danish. “Checks and Balances Amongst Imams: An Interview with Shaykh Tameem Ahmadi.” *In Shaykhs Clothing*, July 2017, inshaykhsclothing.com/interviewtameem/.
16. Qasim, Danish. “Introduction to Spiritual Abuse.” *In Shaykhs Clothing*, 2017, inshaykhsclothing.com/home/intro/.
17. Salem, Alia. “Facing Abuse in Community Environments (FACE) Report of Zia Ul-Haque Sheikh.” *Facetogether.org*, 9 Oct. 2018, facetogether.org/zia-ul-haq-sheikh-irving-texas/.
18. Salem, Alia. “Facing Abuse in Community Environments (FACE) Welcomes $2.5 Million Judgment for the Plaintiff in the Jane Doe vs. Zia Sheikh Trial.” *Facetogether.org,* 13 Aug. 2019, facetogether.org/trial-doe-vs-sheikh/.
19. Smith, Jennifer. *Removing Barriers to Therapy with Muslim-Arab-American Clients*. Diss. Antioch University, 2011.
20. Teicher, Martin H., et al. "Developmental neurobiology of childhood stress and trauma." *Psychiatric Clinics of North America* (2002).