

Addressing IPV in Muslim Communities: The Case for Faith-Informed and Culturally Relevant Interventions



*The Professional Counselor*TM
Volume 16, Issue 3, Pages 194–207
<http://tpcjournal.nbcc.org>
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doi: 10.15241/tm.16.3.194

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Intimate partner violence (IPV) remains a critical public health concern, with Muslim women in the United States encountering distinct cultural and structural barriers when navigating support systems. Though survivors frequently utilize informal networks like family and community peers, these resources often yield inconsistent and unreliable outcomes. Concurrently, formal systems such as emergency shelters, legal services, and law enforcement frequently present barriers marked by cultural insensitivity and limited accessibility. To address these systemic gaps, this conceptual article proposes a culturally grounded framework designed to strengthen informal pathways of care through empowering peer-based networks. Utilizing an illustrative case study application, our article demonstrates how integrated advocacy can foster survivor empowerment, cultivate coping skills, and build long-term resilience. The implications extend to community programming, policy, and future research. We offer a practice-oriented model to reduce stigma and establish consistent, trustworthy interventions for Muslim women experiencing IPV.

Keywords: intimate partner violence, Muslim women, case study application, peer-based networks, interventions

Intimate partner violence (IPV) represents a global public health crisis that affects approximately 1 in 3 women worldwide (World Health Organization, 2021). Within the United States, IPV impacts an estimated 10 million individuals each year (Huecker et al., 2023). The Centers for Disease Control and Prevention (CDC) conceptualizes IPV as a pattern of behaviors encompassing physical violence, sexual violence, stalking, and psychological aggression employed by current or former partners to maintain power and control over a victim (Huecker et al., 2023).

Although this remains an emerging area of research, recent national data highlights a persistent prevalence of IPV among American Muslims, a large community of 3.45 million people of diverse racial and ethnic backgrounds (Pew Research Center, 2017). For instance, a national survey of 366 American Muslims, conducted in collaboration with the Peaceful Families Project, indicated that 40% of Muslim women and 10% of Muslim men reported experiencing IPV (American Muslim Intimate Partner Violence Study [AMIPV]; Oyewuwo et al., 2024). This prevalence remains consistent across racial, socioeconomic, and immigration lines, illustrating that IPV cuts across demographic boundaries and operates as a deeply rooted, multifaceted issue within this community (Oyewuwo et al., 2024). Rather than being isolated incidents, these patterns are sustained by intersecting cultural misconceptions, structural systemic barriers, and a lack of specialized community training, which together reinforce cycles of abuse and deter victims from seeking safety.

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Furthermore, Muslim women experience diverse configurations of abuse, including physical, sexual, financial, social, and psychological coercion (Sharifnia et al., 2025). Among these, psychological and emotional violence are most frequently documented; these forms significantly undermine a survivor's self-worth and well-being, often preceding the escalation to physical abuse (Sharifnia et al., 2025). Consequently, Muslim women navigate distinct cultural, religious, and systemic barriers that uniquely complicate their lived experiences and restrict their overall access to traditional support systems (Afrouz et al., 2018; Sharifnia et al., 2025).

This article examines IPV in Muslim communities in the United States, highlighting the potential of peer support psychoeducation to enhance knowledge, reduce stigma, and increase willingness to intervene. The discussion emphasizes the need for culturally and religiously responsive interventions that move beyond traditional, one-size-fits-all IPV models in order to address the unique needs of this population.

Religion and IPV in Muslim Communities

At its core, Islam emphasizes central values like justice, compassion, equality, and accountability (Hamid, 2015). These principles dictate that human interactions must be built on mutual respect, which strictly forbids oppression or the causing of harm to others. Within family life, *The Qur'an* explicitly mandates that the marital relationship be anchored in tranquility and mercy, framing the home as a sanctuary of safety. Grounded in these values, Islam explicitly grants women spiritual, social, and legal rights, including the ability to own property, earn income, seek education, and choose to marry or to leave a marriage (Hamid, 2015). *The Qur'an* emphasizes the moral and spiritual equality of women and men and holds both accountable for their actions. Though cultural practices have historically distorted these values, Islamic teachings, at their core, promote dignity, equity, and compassion for women (Hamid, 2015).

The Intersection of Patriarchy, Culture, and Religious Practice

Across faith traditions, religious values and practices shape community responses to IPV, and Muslim communities are no exception (Alkhateeb & Abugideiri, 2007; Ghafournia, 2017). Islamophobic narratives that conflate Islam with IPV both stigmatize Muslim communities and obscure the faith's foundational emphasis on gender equity and nonviolence (Hamid, 2015). These external narratives amplify IPV risks by increasing a survivor's fear of reporting abuse, as victims often choose to hide their experiences in order to avoid validating mainstream anti-Muslim stereotypes or exposing their community to external surveillance (Hassounah & Kulwicki, 2007; Hulley et al., 2022). Within Muslim contexts, religion and culture are often intertwined. Sometimes they function as protective resources and at other times as tools that reinforce harm. Oversimplifying this dynamic as exclusively positive or negative risks erasing the complexity of survivors' lived experiences (Hamid, 2015).

In Muslim communities, cultural norms and Islamic values are often closely intertwined, influencing how religious teachings are interpreted and applied within families and communities (Ghafournia, 2017). Across the literature, a consistent distinction emerges between Islam's core principles, which emphasize compassion, justice, mutual respect, and the prohibition of harm, and the patriarchal cultural interpretations that have been used to legitimize male authority and women's subordination (Alkhateeb & Abugideiri, 2007; Jayasundara et al., 2014). Systematic reviews and qualitative studies identify cultural expectations surrounding female submissiveness, preservation of family honor, shame associated with marital dissolution, and prioritization of family unity as factors

that contribute to the justification, normalization, and continuation of IPV (Alghamdi et al., 2021; Gennari et al., 2017; Jayasundara et al., 2014). These findings suggest that barriers to help-seeking often arise not from Islamic teachings themselves, but from the conflation of patriarchal cultural traditions with religious practice (Ghafournia, 2017).

This distinction is reflected in survivors' lived experiences. Drawing on in-depth qualitative interviews with 14 Muslim immigrant women who experienced IPV, survivors consistently described spirituality as an important source of comfort, resilience, and hope, with prayer and *Qur'an* recitation serving as meaningful coping strategies throughout the abuse (Ghafournia, 2017). However, many participants also described receiving messages from family members and religious leaders that emphasized patience, forgiveness, and preserving the marriage, even when abuse persisted, which created spiritual and emotional barriers to seeking safety (Ghafournia, 2017; Pinter et al., 2016). Similarly, focus groups with 42 first-generation Muslim immigrants from Morocco, Egypt, and Pakistan demonstrated that although attitudes toward IPV varied across cultural groups, patriarchal gender norms consistently prioritized male authority, family reputation, and marital preservation over women's individual safety (Gennari et al., 2017). It is important to note that survivors frequently distinguished these experiences from Islam itself, emphasizing that their faith protects women's dignity and rights, but that these principles are often overshadowed by male-dominated interpretations of scripture and culturally reinforced gender roles (Gennari et al., 2017; Ghafournia, 2017).

Perspectives from frontline service providers further reinforce these findings. A qualitative phenomenological study involving providers with extensive experience serving Muslim survivors identified immigration-related stress, collectivist family structures, patriarchal gender norms, honor and shame, and the misuse of religious teachings as intersecting factors that shape survivors' experiences and contribute to barriers to help-seeking (Milani et al., 2018). Providers described instances in which women had internalized beliefs portraying men as religious authorities and women as inherently subordinate, illustrating how patriarchal interpretations of faith can become deeply embedded within survivors' self-perceptions and decision-making (Milani et al., 2018). Collectively, these findings demonstrate that the authority of family members, community leaders, and religious leaders may either facilitate help-seeking by affirming women's rights or reinforce abuse when family preservation is prioritized over survivor safety (Alkhateeb & Abugideiri, 2007; Milani et al., 2018; Pinter et al., 2016).

These findings have important implications for intervention. Helping survivors distinguish Islamic principles from patriarchal cultural interpretations may reduce self-blame, strengthen self-worth, and increase confidence in making safety-focused decisions (Finigan, 2010; Ghafournia, 2017). Culturally responsive advocacy that promotes empowerment, assertiveness, healthy boundaries, and faith-consistent understandings of dignity and justice may help survivors challenge harmful beliefs while preserving the protective role that spirituality often plays in coping and recovery (Finigan, 2010; Ghafournia, 2017). Together, these findings suggest that the consequences of IPV extend beyond the relationship itself. The interaction of patriarchal cultural norms, restrictive interpretations of faith, and barriers to help-seeking can profoundly affect survivors' psychological, emotional, relational, and spiritual well-being, highlighting the importance of understanding the broader impact of abuse on Muslim women.

Impact of IPV on Muslim Survivors

A deeper conceptual understanding of how abuse affects the psychological well-being of Muslim survivors was established through a meta-ethnography synthesizing 33 qualitative studies involving

764 Muslim women across 21 countries, drawing on interviews and focus groups (Sharifnia et al., 2025). By systematically comparing findings across these diverse investigations, the synthesis reveals the profound internal toll of ongoing abuse. Survivors frequently describe enduring pervasive feelings of worthlessness, hopelessness, helplessness, emotional numbness, physical and mental exhaustion, and a sense of total entrapment in their marriages (Hassouneh & Kulwicksi, 2007; Sharifnia et al., 2025). Experiencing this form of recurrent trauma impacts survivors by fracturing their core sense of identity, causing chronic psychological hypervigilance, and creating a profound internal alienation (Hassouneh & Kulwicksi, 2007; Sharifnia et al., 2025). Furthermore, some women express humiliation and an underlying desire for retribution, while others carry persistent regret and guilt that is actively reinforced by their spouses' psychological manipulation and compounding pressures from extended in-laws (Ghafournia, 2017; Sharifnia et al., 2025). These chronic emotional injuries can develop into severe crises, sometimes escalating to suicidal thoughts. Within these contexts, external accusations of infidelity frequently drive women to consider or attempt suicide as a means to escape social stigma and communal dishonor (Alghamdi et al., 2021; Hassouneh & Kulwicksi, 2007; Sharifnia et al., 2025). Additionally, pervasive communal shame and feelings of spiritual abandonment heavily discourage survivors from disclosing their abuse to their external networks (Alghamdi et al., 2021; Ghafournia, 2017; Sharifnia et al., 2025). These findings highlight how the cumulative psychological toll of IPV not only undermines immediate mental health but also fundamentally dictates the restrictive patterns of formal and informal help-seeking that we will examine in the following section (Sharifnia et al., 2025).

Help-Seeking Practices Among Muslim Victims of IPV

Help-seeking in the context of IPV is not monolithic but occurs across multiple networks of support. The literature commonly distinguishes between formal networks, which encompass services provided by law enforcement, healthcare providers, emergency shelters, and formal advocacy organizations, and informal networks, which include family, friends, and other community members operating outside of public care systems (Fleming & Resick, 2016). Research demonstrates that survivors turn first to informal supports, which they are drawn to because of their immediate accessibility and perceived safety when compared to formal systems. Survivors often avoid formal help-seeking because they fear social stigma, breaches of confidentiality, retaliation, or harmful encounters with institutional systems (Fleming & Resick, 2016; Oyewuwo-Gassikia, 2016). Because survivors gauge the risks and benefits of seeking outside intervention, informal disclosure may also serve as a critical precursor to formal help-seeking. This distinction is particularly important for understanding Muslim survivors' pathways to support, in which both cultural and religious dynamics shape disclosure decisions across formal and informal spaces (Hansia & Merolla, 2021).

Formal Help-Seeking

Formal help-seeking among Muslim women is shaped by a complex interplay of cultural, religious, and systemic barriers. Experiences of Islamophobia, inadequate cultural responsiveness, language barriers, and limited accommodation of religious practices frequently complicate survivors' efforts to access shelters, healthcare systems, counseling services, legal resources, and law enforcement (Oyewuwo-Gassikia, 2016; Rabaan & Dombrowski, 2023; Sharifnia et al., 2025). These challenges often coexist with concerns about family privacy, community stigma, immigration-related vulnerabilities, and religious interpretations emphasizing endurance and marital preservation, which create additional obstacles to seeking support (Oyewuwo-Gassikia, 2016; Sharifnia et al., 2025). Many women delay seeking formal assistance until abuse becomes severe or intolerable (Sharifnia et al., 2025). Feelings of shame, fear of community judgment, limited awareness of available services,

and concerns about confidentiality contribute to their reluctance to disclose abuse and engage with formal systems (Oyewuwo-Gassikia, 2016; Sharifnia et al., 2025). These barriers often leave survivors weighing the risks of disclosure against the potential benefits of receiving support.

Experiences within formal service systems vary considerably. Some survivors report receiving validation, advocacy, and meaningful support from shelters, healthcare providers, legal professionals, and counselors (Rabaan & Dombrowski, 2023; Sharifnia et al., 2025). Others describe encounters that were dismissive, culturally insensitive, or ineffective, particularly when providers failed to recognize the significance of religious identity, cultural context, or nonphysical forms of abuse (Rabaan & Dombrowski, 2023). Such experiences can reinforce mistrust of institutions and contribute to continued reliance on informal sources of support despite their limitations (Rabaan & Dombrowski, 2023; Sharifnia et al., 2025).

Collectively, these findings highlight the fact that barriers to formal help-seeking extend beyond individual decisions to disclose abuse and reflect broader shortcomings within service delivery systems. Limited cultural responsiveness, insufficient coordination among providers, and inadequate attention to the religious and social realities shaping Muslim women's experiences may undermine access to care and contribute to revictimization (Oyewuwo-Gassikia, 2016; Rabaan & Dombrowski, 2023; Sharifnia et al., 2025). Addressing these barriers requires culturally responsive and survivor-centered approaches that integrate religious literacy, cultural humility, and collaboration with Muslim communities.

Informal Help-Seeking

For many Muslim women, informal support networks represent the first and most accessible avenue for seeking help. They often reach out to family members, friends, and religious leaders before approaching formal service providers because they perceive those people as trusted, familiar, and culturally meaningful sources of support (Afrouz et al., 2018; Khan et al., 2022). Informal networks may provide emotional validation, practical assistance, and encouragement to seek safety; however, the quality of support varies considerably. Family and community responses are often shaped by concerns about family honor, privacy, and marital preservation (Afrouz et al., 2018; Khan et al., 2022). Though some relatives and friends encourage disclosure and support survivors' decisions to leave abusive relationships, others respond with victim blaming, pressure to remain silent, or encouragement to endure abuse for the sake of family cohesion (Khan et al., 2022). Fear of stigma and community judgment further influence whether women disclose abuse and to whom they turn for assistance (Afrouz et al., 2018).

Religious leaders occupy a particularly complex role within survivors' help-seeking experiences. Many women view imams and other faith leaders as trusted sources of guidance because they possess cultural and religious knowledge that may be absent within mainstream service systems (Khan et al., 2022; Rabaan & Dombrowski, 2023). Some religious leaders provide emotional support, validate survivors' experiences, and facilitate access to resources, whereas others prioritize marital reconciliation or lack adequate training to respond effectively to IPV (Afrouz et al., 2018; Khan et al., 2022). As a result, faith-based support can function as either a protective factor or an additional barrier to safety.

Disclosure patterns are also influenced by social identity and community belonging. Muslim individuals report greater willingness to seek support from Muslim family members and friends when the perpetrator is Muslim, whereas disclosure to non-Muslim networks increases when the

perpetrator is perceived as outside the Muslim community (Hansia & Merolla, 2021). Higher levels of religiosity are associated with stronger preferences for Muslim support networks, while perceived marginalization is associated with lower rates of disclosure across multiple sources of support (Hansia & Merolla, 2021).

These findings suggest that informal support networks serve as both a critical resource and a potential source of harm for Muslim women experiencing IPV. Family members, friends, and religious leaders often provide the first opportunity for disclosure and intervention, yet their responses are frequently constrained by stigma, family honor concerns, patriarchal norms, and varying levels of knowledge about IPV (Afrouz et al., 2018; Khan et al., 2022). Strengthening informal help-seeking pathways requires community-based efforts that reduce stigma, increase IPV awareness, improve bystander intervention, and equip community and faith leaders with evidence-based knowledge and referral skills.

Proposed Conceptual Framework of Knowledge and Stigma in Help-Seeking

The findings synthesized across the literature suggest that help-seeking among Muslim women experiencing IPV is influenced by multiple interacting factors rather than a single barrier or facilitator. Based on the themes identified in our review, this section proposes a conceptual framework that highlights two interrelated constructs—knowledge and stigma—as key influences on survivors’ disclosure decisions, help-seeking behaviors, and the responses they receive from informal support networks. Although these constructs are presented separately for clarity, they operate in a dynamic manner that shapes both individual decision-making and community responses to IPV. The proposed framework provides a foundation for understanding these relationships and offers direction for counseling practice and community interventions.

Knowledge

When informal support networks respond inconsistently to IPV disclosures, gaps in knowledge often emerge as a contributing factor. Knowledge influences whether survivors recognize abuse, understand available options for support, and identify pathways to safety. Across the literature, limited awareness of IPV dynamics, legal protections, counseling services, shelters, and advocacy resources repeatedly emerged as barriers to help-seeking among Muslim women (Afrouz et al., 2018; Kulwicki et al., 2010; Oyewuwo-Gassikia, 2016). Many survivors reported uncertainty regarding the role of formal systems such as law enforcement and the courts, while others remained unaware of available services until violence had significantly escalated (Kulwicki et al., 2010; Oyewuwo-Gassikia, 2016).

Knowledge deficits often extend beyond survivors themselves and affect the broader support systems on which women rely. Family members, community leaders, and faith leaders may lack the information necessary to recognize abuse, respond appropriately to disclosures, or connect survivors with culturally relevant resources (Afrouz et al., 2018; Oyewuwo-Gassikia, 2016; Rabaan & Dombrowski, 2023). Survivors also reported difficulty locating trustworthy information and culturally responsive guidance regarding available services and legal protections, limiting opportunities for timely intervention and support (Rabaan & Dombrowski, 2023). These findings suggest that knowledge functions as both an individual and community-level factor influencing how IPV is understood and addressed. Limited knowledge may delay recognition of abuse, contribute to misconceptions regarding available resources, and increase reliance on informal advice that does not always promote safety (Kulwicki et al., 2010; Oyewuwo-Gassikia, 2016). Conversely, greater

awareness of IPV warning signs, coercive control, legal rights, and available services may facilitate earlier help-seeking and strengthen the capacity of informal support networks to respond effectively when abuse is disclosed (Afrouz et al., 2018; Kulwicki et al., 2010).

The literature further suggests that the increasing of knowledge requires intervention at both the individual and community levels. Educational initiatives delivered through mosques, community organizations, social media platforms, and faith leader training programs may improve awareness of IPV and available resources while increasing confidence in those responding to disclosures (Kulwicki et al., 2010; Oyewuwo-Gassikia, 2016; Rabaan & Dombrowski, 2023). Through psychoeducation, counselors can make contributions regarding healthy relationships, coercive control, safety planning, and community resources, which will help survivors and their support systems make informed decisions regarding safety and intervention.

Within the proposed conceptual framework, knowledge alone may be insufficient to promote help-seeking when stigma surrounding abuse remains pervasive. Even when survivors recognize abuse and understand available options, concerns about shame, judgment, and family reputation may continue to discourage disclosure and support-seeking (Khan et al., 2022; Oyewuwo-Gassikia, 2016; Sharifnia et al., 2025). This highlights the importance of stigma as a second construct influencing whether knowledge ultimately translates into action.

Stigma

Stigma consistently emerges as one of the most significant barriers to disclosure and support-seeking among Muslim women experiencing IPV. Across studies, survivors described fears of shame, judgment, social exclusion, and damage to family reputation as powerful deterrents to seeking help (Alghamdi et al., 2021; Khan et al., 2022; Kulwicki et al., 2010; Sharifnia et al., 2025). Disclosure was often viewed as threatening to family honor or exposing private family matters to public scrutiny, creating pressure to remain silent even when abuse was severe (Sharifnia et al., 2025). These experiences were reinforced by cultural norms that emphasized privacy, endurance, and family preservation, contributing to the normalization or minimization of abuse within some community contexts (Khan et al., 2022; Rabaan & Dombrowski, 2023).

Stigma also shapes how survivors are treated when they disclose abuse. Women frequently reported encountering victim-blaming attitudes, pressure to preserve marriages, and responses that prioritized family reputation over personal safety (Khan et al., 2022; Sharifnia et al., 2025). Such responses may contribute to self-blame, secrecy, and reluctance to access both formal and informal support systems, which leaves survivors increasingly isolated from potential sources of help (Rabaan & Dombrowski, 2023). Consequently, stigma functions not only as a barrier to disclosure, but also as a mechanism that perpetuates silence, denial, and limited community accountability regarding IPV (Alghamdi et al., 2021; Rabaan & Dombrowski, 2023).

The relationship between knowledge and stigma is particularly important. Increasing awareness of IPV and available resources may have limited impact if survivors continue to fear judgment or social consequences associated with disclosure. Likewise, reducing stigma without improving knowledge may leave survivors and community members uncertain about how to respond when they recognize abuse. These findings suggest that knowledge and stigma operate as interconnected constructs that influence help-seeking, disclosure decisions, and community responses to IPV (Afrouz et al., 2018; Alghamdi et al., 2021; Khan et al., 2022; Sharifnia et al., 2025).

Addressing stigma therefore requires interventions that target both individual beliefs and broader community norms. Counselors can help survivors challenge internalized shame, reduce self-blame, and develop alternative narratives that emphasize resilience, dignity, and empowerment rather than secrecy and personal responsibility for abuse (Bridge & Duman, 2019; Jordan, 2017). Self-compassion interventions, narrative approaches, and strengths-based practices may be particularly useful in supporting this process (Jordan, 2017). Community-level interventions are equally important. Educational initiatives, survivor-informed awareness campaigns, and faith-based discussions that openly address IPV may help challenge harmful beliefs and reduce barriers to disclosure (Khan et al., 2022; Sharifnia et al., 2025). Religious leaders are particularly well-positioned to influence these efforts by promoting survivor-centered interpretations of faith, emphasizing safety and justice, and encouraging supportive responses to survivors who seek help (Khan et al., 2022; Rabaan & Dombrowski, 2023). Through these combined efforts, reducing stigma may create conditions in which increased knowledge can more effectively translate into disclosure, support-seeking, and access to safety.

Peer Support

Informal peer support has emerged as an important source of assistance for survivors of IPV, particularly when formal services are perceived as inaccessible, culturally incongruent, or unable to address the relational and emotional needs of survivors (Hulley et al., 2022; Osborn et al., 2024). Unlike traditional service models that position survivors as recipients of professional expertise, peer-based approaches draw upon shared lived experiences in order to foster trust, connection, and mutual understanding. Survivors frequently describe peer relationships as more accessible and relatable than formal services because they provide support from individuals who have navigated similar challenges and can offer guidance grounded in personal experience (Gilbert, 2026; Osborn et al., 2024).

Across the literature, peer support appears to promote validation by reducing survivors' sense of isolation and affirming that their experiences are real, understandable, and deserving of support (Gilbert, 2026; Osborn et al., 2024). Many survivors of IPV report questioning their perceptions of abuse or internalizing blame because of repeated experiences of minimization, victim-blaming, or stigma (Khan et al., 2022; Sharifnia et al., 2025). Peer supporters who have experienced similar circumstances can challenge these narratives by normalizing survivors' reactions, validating emotional experiences, and providing reassurance that help-seeking is both appropriate and justified (Gilbert, 2026; Osborn et al., 2024). This process may strengthen survivors' confidence in their own experiences while reducing shame and self-blame. Peer support also enhances understanding by translating lived experience into practical knowledge and guidance. Survivors often report uncertainty regarding available resources, safety planning, legal options, and the help-seeking process (Afrouz et al., 2018; Oyewuwo-Gassikia, 2016). Individuals with lived experience may be uniquely positioned to share information in ways that feel credible, accessible, and culturally relevant, which helps survivors navigate challenges that formal systems sometimes fail to address (Gilbert, 2026; Osborn et al., 2024). In this way, peer support may bridge the gap between knowledge and action by helping survivors understand their options and the practical realities of seeking support.

The literature further suggests that peer relationships contribute to resilience by fostering hope, empowerment, and a renewed sense of agency (Gilbert, 2026; Osborn et al., 2024). Witnessing another survivor's ability to heal, access support, and rebuild their life may provide tangible evidence that recovery is possible. At the same time, peer mentors often describe deriving meaning and purpose from supporting others, creating reciprocal benefits that strengthen both individual and collective resilience (Gilbert, 2026). Rather than focusing solely on crisis management, peer interventions may

help survivors reconnect with personal strengths, develop supportive relationships, and cultivate a sense of belonging within a broader community of survivors. For Muslim women experiencing IPV, peer-based interventions may be particularly valuable because they offer support that is culturally resonant and grounded in shared community experiences. Survivors often report concerns about stigma, privacy, and being misunderstood when seeking help through formal systems or traditional community structures (Rabaan & Dombrowski, 2023; Sharifnia et al., 2025). Peer support delivered by other Muslim women may help address these concerns by providing culturally relevant validation, reducing isolation, and fostering trust within a supportive relational context.

Case Study: Layla and Noor

Layla is a 32-year-old Muslim woman who has been married for 8 years and lives in a close-knit Muslim community in the United States. During the past 3 years, her husband's behavior has become increasingly controlling and emotionally abusive. He routinely criticizes her appearance, restricts her contact with family and friends, monitors her communication, and undermines her confidence as a mother. More recently, his behavior has escalated to include threats of physical violence. Although Layla recognizes that her marriage has become increasingly distressing, she questions whether her experiences are "serious enough" to justify seeking help and wonders whether she should simply be more patient or forgiving. Over time, she has begun to internalize responsibility for the abuse, which has made it increasingly difficult for her to recognize her own need for support.

Layla has considered reaching out for help, but she remains uncertain about where she could safely turn. She worries that disclosing the abuse to members of her community could lead to gossip, judgment, or damage to her family's reputation. She also fears that approaching her local imam may result in encouragement to preserve the marriage rather than prioritize her safety. Although professional counseling is another option, Layla is unfamiliar with available IPV services and is uncertain whether she could find a provider who understands her religious beliefs, cultural values, and family context. Because she has never spoken with another Muslim woman who has experienced IPV, Layla feels isolated and believes that she must navigate her situation alone.

Noor, one of Layla's closest friends, has noticed significant changes in Layla's behavior over the past several months. Layla has become increasingly withdrawn, frequently cancels plans, appears anxious whenever her husband contacts her, and rarely participates in community gatherings. Noor suspects that something is wrong, but she is uncertain whether what she is observing constitutes abuse and whether it is appropriate for her to intervene. She worries that raising the topic might embarrass Layla, damage their friendship, or unintentionally place her at greater risk if her husband were to discover the conversation. Noor also feels unprepared to navigate the cultural and religious complexities surrounding IPV and is unsure where she could direct Layla to for culturally appropriate support if abuse were disclosed.

Concerned about Layla's increasing isolation, Noor gently expresses her concern and reassures Layla that she is available to listen without judgment. Feeling supported rather than criticized, Layla discloses the abuse and agrees to seek counseling with a licensed professional counselor who has experience working with survivors of IPV and demonstrates cultural responsiveness to Muslim clients. During the initial counseling sessions, Layla describes years of emotional abuse, increasing isolation, uncertainty regarding whether her experiences constitute abuse, and fears of being judged by her community if she seeks help. The counselor recognizes that Layla's reluctance to seek support has been influenced not only by the abuse itself, but also by limited knowledge of IPV dynamics,

concerns regarding community stigma, and uncertainty about culturally responsive services. Layla's experiences, together with Noor's uncertainty about how to respond, illustrate how limited knowledge, stigma surrounding IPV, and hesitation within informal support networks can prevent both survivors and supportive community members from accessing or facilitating help.

Applying the Proposed Conceptual Framework to the Case Study

Layla's presentation in counseling illustrates the central premise of the proposed conceptual framework, which suggests that knowledge and stigma interact to influence survivors' disclosure decisions, help-seeking behaviors, and responses from informal support networks. Rather than conceptualizing Layla's reluctance to seek help as an individual deficit, the counselor understands her experiences within the broader context of limited knowledge, community stigma, and uncertainty regarding culturally responsive resources. Guided by this framework, the counselor develops a treatment plan that addresses both Layla's individual needs and the broader social and cultural factors influencing her help-seeking while also strengthening supportive relationships within her informal support network.

The first component of Layla's counseling focuses on increasing knowledge of IPV-related dynamics. The counselor provides Layla with psychoeducation regarding the dynamics of IPV, including coercive control, emotional abuse, trauma responses, and the cycle of abuse. Together, they explore culturally responsive community resources, legal protections, safety planning, shelters, advocacy organizations, and other community services available to Muslim women experiencing IPV. The counselor also helps Layla explore differences between cultural expectations and Islamic teachings that emphasize justice, dignity, and protection from harm rather than endurance of abuse. As Layla develops a greater understanding of IPV and available resources, she becomes better equipped to recognize the abuse, evaluate her options, and make informed decisions regarding her safety. With Layla's consent, the counselor also encourages Noor to participate in community-based or faith-informed educational opportunities that increase awareness of IPV and strengthen her ability to provide informed, supportive responses. A second component of Layla's counseling addresses the effects of stigma on Layla's help-seeking and recovery. Through cognitive restructuring, self-compassion, and strengths-based interventions, Layla begins to replace self-critical beliefs with more adaptive perspectives that emphasize her dignity, resilience, and right to safety. The counselor also facilitates discussions that distinguish harmful cultural expectations from religious principles that support protection from abuse and personal well-being. By addressing internalized stigma while affirming Layla's faith and cultural identity, counseling reduces psychological barriers that have contributed to her reluctance to seek support.

The proposed framework also highlights the importance of strengthening informal support networks as part of the counseling process. Rather than viewing Noor solely as a concerned friend, the counselor recognizes her potential role as a supportive member of Layla's recovery. With Layla's permission, the counselor discusses strategies for reconnecting with trusted individuals who can provide validation, encouragement, and practical assistance while respecting Layla's autonomy. The counselor also recommends participation in a culturally responsive peer support group facilitated by Muslim women with lived experience or specialized IPV training. These relationships provide opportunities for Layla to reduce isolation, challenge self-blame, receive practical guidance regarding safety planning and available resources, and develop hope through connection with others who understand the intersection of faith, culture, and abuse. Simultaneously, Noor's increased knowledge and confidence enhance her ability to respond with empathy, validation, and appropriate referrals rather than uncertainty or silence.

Implications for Counseling Practice

The literature synthesized in our article and the accompanying case illustration suggest that counselors can play an important role in addressing barriers to help-seeking among Muslim women experiencing IPV by integrating culturally responsive counseling with efforts to strengthen informal support networks. Survivors' help-seeking pathways are shaped by the complex interplay of cultural expectations, religious beliefs, stigma surrounding disclosure, limited knowledge of available resources, and the responsiveness of both formal and informal support systems. Because many Muslim women first disclose abuse to trusted friends, family members, or other informal supports before engaging formal services, counselors should recognize the influential role these relationships play in facilitating or hindering access to safety and care. Drawing on the literature reviewed and the conceptual framework proposed in this article, the following recommendations provide evidence-informed strategies for strengthening culturally responsive counseling, promoting survivor empowerment, and enhancing collaboration with the informal support networks that often serve as survivors' first point of support.

First, counselors should develop an understanding of the cultural values and religious beliefs that influence Muslim women's experiences of IPV and help-seeking behaviors. Cultural competence enables counselors to recognize abuse within its cultural context while avoiding stereotypes or assumptions regarding Muslim families (Abdulraof & Guro, 2025; Bridge & Duman, 2019). Beyond direct clinical work, this knowledge prepares counselors to collaborate with Muslim community organizations, consult with faith leaders, and develop culturally responsive psychoeducational initiatives that strengthen informal support systems and increase community awareness of IPV.

Second, family members, friends, and faith communities frequently influence survivors' decisions regarding disclosure, safety planning, and help-seeking. Counselors should assess the role of these relationships while helping survivors identify individuals who promote safety, validation, and empowerment (Bridge & Duman, 2019; Jordan, 2017). Clinical tools such as genograms and social network mapping may assist counselors in identifying supportive relationships and recognizing barriers within clients' social environments. When appropriate, counselors can also collaborate with trusted community members to strengthen informal support networks and facilitate culturally responsive referral pathways.

Third, limited knowledge of IPV, available resources, legal protections, and healthy relationship dynamics continues to delay help-seeking among many Muslim women (Abdulraof & Guro, 2025; Oyewuwo-Gassikia, 2016). Counselors can address these barriers by providing culturally responsive psychoeducation that increases awareness of safety planning, community resources, and available services. Extending psychoeducation beyond individual counseling through workshops, consultation with community organizations, and educational programming for peer supporters and faith leaders may further strengthen the knowledge and confidence of those most likely to receive survivors' initial disclosures.

Fourth, fear of community judgment, shame, and concerns about family reputation often discourage Muslim women from disclosing abuse or seeking support outside their immediate social networks (Bridge & Duman, 2019; Tanhan & Young, 2022). Counselors can reduce these barriers by fostering therapeutic relationships characterized by cultural humility, validation, confidentiality, and trust. At the community level, counselors may collaborate with faith leaders and community organizations to facilitate psychoeducational workshops and stigma-reduction initiatives that encourage supportive responses to disclosure and challenge beliefs that normalize abuse or discourage help-seeking.

Fifth, prolonged exposure to IPV frequently undermines survivors' confidence, autonomy, and sense of self-worth (Sharifnia et al., 2025). Counselors can foster empowerment by incorporating assertiveness training, boundary-setting exercises, communication skills training, and collaborative problem-solving into treatment. Cognitive restructuring may help survivors challenge internalized self-blame and maladaptive beliefs, while self-compassion interventions, narrative therapy, and strengths-based approaches may promote self-worth, resilience, and post-traumatic growth. Throughout treatment, counselors should reinforce survivors' capacity for self-determination, encouraging them to make informed decisions that align with their values, priorities, and readiness for change (Jordan, 2017).

Collectively, these recommendations extend the counselor's role beyond individual therapy to include collaboration with peer supporters, faith leaders, and community organizations. By strengthening the knowledge and responsiveness of informal support networks while simultaneously empowering survivors through culturally responsive and faith-informed counseling, counselors can help create coordinated systems of care that promote earlier intervention, reduce stigma, and improve access to culturally congruent support for Muslim women experiencing IPV. Counselors may also engage in action research to evaluate the implementation and effectiveness of culturally responsive, community-based interventions within their own practice settings. Examining outcomes such as changes in survivors' help-seeking behaviors, perceptions of social support, and collaboration with informal support networks can inform ongoing program development and contribute to the growing evidence base for counseling interventions with Muslim women experiencing IPV.

Conclusion

Muslim women experiencing IPV frequently encounter inconsistent and, at times, inadequate responses from both formal and informal support systems. Although barriers such as stigma, limited knowledge, and concerns regarding cultural responsiveness continue to delay help-seeking, the literature highlights opportunities for counselors to strengthen the community relationships that often serve as survivors' first source of support by recognizing family members, friends, and faith communities as protective resources and providing culturally responsive psychoeducation, addressing stigma, and promoting the knowledge and skills needed to effectively respond to disclosures of IPV.

The conceptual framework proposed in our article emphasizes increasing knowledge, addressing stigma, and strengthening informal support networks as interconnected strategies for improving help-seeking and complementing formal counseling services. Through psychoeducation, stigma reduction, survivor empowerment, collaboration with faith leaders and community organizations, and counselor-led community engagement, this framework offers a practical approach to promoting earlier help-seeking, increasing access to culturally congruent care, and enhancing opportunities for safety and healing among Muslim women experiencing IPV. By integrating culturally responsive counseling with strengthened peer support and community collaboration that extends beyond the counseling office into the communities where survivors live, worship, and seek support, counselors can help foster environments in which survivors encounter validation, empowerment, and meaningful pathways toward recovery.

Conflict of Interest and Funding Disclosure

The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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