A review of mental health strategies among minorities to inform approaches for help seeking for Muslim Canadians

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Abstract

Muslim Canadians are a diverse group who face unique challenges when it comes to accessing mental health services. It has been established that Muslims face discrimination from healthcare providers and stigma from their own communities when accessing mental health care however, research has not explored how help seeking can be improved for this community. With Islam being the fastest growing religion in Canada, there is a need to evaluate ways to increase help seeking among this population. To inform effective help seeking approaches, one can take lessons from other minority groups that share similarities with Muslim Canadians such as Jewish and South Asian populations in western contexts. In doing so, we find that intersectionality and prioritizing community-based interventions are major themes that can increase help seeking among Muslim Canadians and need to be further explored. Training therapists to be understanding of faith-based decisions and training religious leaders (i.e., imams) counselling strategies help build rapport and are effective methods that may apply to Muslim Canadians. Therapists need to ensure they understand their clients' religious needs in order to make appropriate recommendations for treatments that aligns with Islamic religious views. Imams work closely with the Muslim community and provide regular religious counselling yet they lack training on supporting mental health. External organizations catering to Muslims and minorities can support imams by showcasing relevant services and training can help imams become more comfortable counselling Muslims on mental health. Together, these approaches may support help seeking initiatives for the Muslim minority population in Canada.

Keywords: Muslims, Canada, mental health, help seeking

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Islam is the fastest growing religion in the world with over 1.9 billion adherents worldwide. Islam is also the fastest growing religion in Canada due to high immigration rates from Muslim countries ("Survey Shows Muslim Population is Fastest", 2013). In Canada, Muslims are a minority since they only make up 3.2% of Canada's population ("Canada Day... by the Numbers", 2017). Religious minorities have unique needs and face different challenges from majority groups so it is crucial for there to be services who can provide culturally competent care ("Mental Health Disparities: Diverse Populations", 2018; Amri & Bemak, 2012; APA, 2018). One important challenge for Muslims in Canada is the issue of help seeking. Help seeking behaviour is defined as "an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns," (Rickwood & Thomas, 2012, p.180). Many Muslims feel that current services are inadequate to meet their psychological needs (Abedi, 2018).

Barriers to accessing mental health services is a major challenge for the general population but it is especially significant for the minorities living in these countries. Studies have found that cultural minorities face unique challenges in healthcare even if it seems that everyone has equal access to care (Halwani, 2004). For instance, language barriers and social stigma can deter members from accessing services in the first place. One such minority group that struggles with accessing mental health services is Muslim Canadians (Abedi, 2018). Muslims, people who follow the religion of Islam, are a very heterogenous group, yet they are often misunderstood as being a monolithic group (Syed & Pio, 2018). Therefore, suggestions for improving healthcare and community services should be mindful of the fact that there will not be a "one size fits all" solution. In order to approach such a broad issue, it is therefore important to consider different perspectives and to study similar minority groups in an attempt to understand how best to support the heterogenous Muslim population in Canada.

Help seeking for Muslim Canadians is complicated in that there are internal as well as external barriers to care (Ciftci et al., 2012; Halwani, 2004). Mental health is also a taboo subject among the Muslim community and these views can follow individuals as they immigrate to new countries (Ciftci et al., 2012). For example, if someone is feeling depressed in a relationship it can be linked to lack of faith, spiritual possession, or karma, and not to childhood trauma (Abedi, 2018). This social stigma discourages many individuals from help seeking, causing further struggles with mental health (Aloud & Rathur, 2009). External barriers for minorities include a lack of culturally appropriate services (Latif, 2020), language barriers (Ohtani et al., 2015), and negative experiences (Knaak et al., 2017; Williams, 2018). The combination of internal and external barriers presents a challenge to Muslims seeking help, putting vulnerable people at risk for getting into an unhealthy cycle of poor mental health (Knaak et al., 2017). Since mental health is directly related to overall physical wellbeing, it is crucial to study how help seeking can be improved for Muslim Canadians ("Improving the Health of Canadians", 2009; "Positive Mental Health and Well-being", n.d.).

In a literature review on racism and mental health with a focus on American Muslim immigrants, it was observed that racism and mental health stigma impact psychological wellbeing (Phillips & Lauterbach, 2017). Other minorities such as South Asians and Chinese groups also report similar stigma in the realm of mental health (Kramer et al., 2002; Virdee, n.d). Self-stigma (i.e., shame) among Muslims in accessing mental health services is already established in the literature and is not the topic of this paper (Youssef & Deane, 2006; Ciftci et al., 2013). Therefore, the type of stigma being referenced throughout this paper is social stigma among community members. Stigma can delay help seeking, leading to worse mental health outcomes that affect individuals and by extension their families (Rose, et al., 2018). This stigma can be perceived internally (e.g. feeling ashamed for accessing services) as well as externally (e.g. healthcare providers treating Muslim patients differently). Both may be a result of lack of cultural competency on the part of the therapists combined with a lack of education on mental health

issues among community members (Huang, 2020; Virdee, n.d.). Lack of cultural competency on the part of the therapist may also lead to a fear of accessing services altogether due to negative past experiences (Halwani, 2004). Though research continues to confirm the existence of discrimination from mental health providers towards Muslims (Knaak et al., 2017; Latif, 2020) and other minorities (Knaak et al., 2017; David, 2010), less work is focused on how to improve help seeking by increasing inclusivity and accessibility of mental health services for Canadian Muslims.

One suggestion is to provide culturally competent care through educational training of psychologists and psychotherapists. Muslims may believe that counsellors lack an understanding of Islam and consequently make suggestions that conflict with their beliefs (Amri & Bemak, 2012). Therefore, it is important for counsellors to be trained on different approaches for working with diverse clients especially on how to be respectful towards religious minorities. However, there is no clear outline of how often cultural sensitivity training should be completed or what content should be covered in these trainings. To learn more about this, one can study other minority groups who share similarities with Muslim to draw lessons on how they were able to increase help seeking among Muslims and other minorities.

The question being addressed by this review focuses on how mental healthcare providers and community members among Jewish and South Asian marginalized/minority populations in western contexts have been able to increase help seeking in their communities. These findings will inform help seeking recommendations for supporting Muslim Canadians. Jewish communities share similar beliefs and ways of living as Muslim communities and are also a marginalized group (“Religion: Three Religions, One God”, 2002). South Asian communities are also comparable to Muslim communities in that they face discrimination in the Canadian healthcare system (Virdee, n.d.). It is therefore possible for there to be an overlap in approaches that increase help seeking in these minority groups. Specifically, we can potentially draw lessons from the existing literature on these two groups to inform recommendations

that would be successful for working with Muslim Canadians (i.e., increase help seeking). The findings of this review can inform future interventions for mental health care when working with Muslim Canadians. Success here is operationalized as an increase in help-seeking behaviour on the part of community members as well as a positive change in attitudes towards help seeking. Unfortunately, inadequate information was collected on South Asian communities and reasons behind this is discussed later in the paper.

Methods

Papers on Jewish, South Asian, and Muslim mental health in western contexts were examined using PsycINFO and Google Scholar. The Journal of Muslim Mental Health was also used to find relevant articles. A literature search among these three sources was conducted for eight consecutive weeks starting from June 15, 2021. A backwards search of papers of interest was also conducted to find additional relevant articles. Keywords used were: mental health, stigma, discrimination, multiculturalism, minority groups, Jewish, South Asian, and their associated synonyms. No ethics approval was necessary.

Findings and Discussion

Several recommendations are proposed for increasing help seeking among Muslim Canadians. These are based on findings from studies of Jewish and South Asian mental health campaigns in western contexts. The main themes are: acknowledging intersectionality and prioritizing community-based interventions. Overall, there seem to be several suggestions for potentially increasing help seeking among Muslim Canadians based on successful case study applications. The majority of the articles were from the United States so there is hope that Canada would also find these approaches useful and relevant for its Muslim population given similarities among the two countries.

Acknowledge Intersectionality

Intersectionality

Intersectionality can complicate experiences of mental illness and influence help seeking behaviour. As mentioned previously, the Canadian Muslim population is very diverse and mostly made up of immigrants. Merriam-Webster dictionary defines intersectionality as, “the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups” (n.d.). An example in the context of mental illness is that an individual may have several identities: one religious (Muslim) and two cultural (Canadian + Pakistani) as well as identifying as male and a father. When mental health needs arise, this individual is forced to make a decision based on several unique points of view. They have to balance their Canadian views with their religious views, even though the two may not align. For Muslims, religion plays a key part in the decision-making process because Islam serves as the guide to the way of life. For instance, they may be afraid of seeking help for mental illness because they want to avoid certain drugs that can affect how they behave and think which may then compromise their faith (e.g., drugs that make one feel extremely depressed or suicidal would be looked down upon because suicide is a major sin in Islam). If we consider gender as another factor influencing decision-making, we can see how much more difficult it can be to access services – in Islam it is not encouraged for a man and a woman to meet together alone (Halwani, 2004). Cultural taboo regarding openly talking about mental health or seeking professional help again complicates help seeking behaviour in some religious communities due to interactions among religion and culture (Fischer, 2016). Additionally, for some Muslims seeking mental health care outside the religious community is a looked down upon and seen as a sign of weak faith because they may be expected to exclusively meet with their chaplain or religious leader because it is expected that non-Muslim counsellors would not be able to help (Abedi, 2018). The interactions between concepts such as ethnicity, religious beliefs, and perception of mental illness still need to be explored further (Ciftci et al., 2012).

Double-stigma may also discourage help seeking for Muslim Canadians. Being a Muslim female means facing stigma on two fronts and this is especially salient if the female is visibly Muslim (i.e., wears the *hijab* – an Islamic head covering for women). Negative experiences shared between community members may spread and ultimately discourage some individuals from accessing care because they fear being discriminated against because they "standing out" (Knaak et al., 2017; Williams, 2018). For many minorities, this may mean delaying appointments until culturally appropriate services are available, such as a female therapist for a female client or until someone who is of the same faith can provide treatment (Halwani, 2004; Sanchez et al., 2015). It is therefore crucial to consider the impact of double-stigma and intersectionality among Muslim Canadians, many of whom are immigrants. With regards to first language, since most of Canada's Muslim population are immigrants, having interpreters available may reduce some cultural barriers and increase help seeking as it would make individuals more comfortable attending appointments (Chang et al., 2020).

Culture versus Religion

Continuing with the example from above, a Muslim Pakistani Canadian has both a religious and a cultural identity. Yet, culture and religion may not always agree with each other as individuals can place more importance on one over the other (Abdulla, 2018). For example, an individual may be a follower of Islam yet they may not be a practicing Muslim and are open to accepting treatment that other Muslims would be opposed to. This highlights that religiosity exists on a continuum where individuals may be more religious in one aspect of life but less religious for other aspects. Thus, it is crucial for professionals to be aware of their biases and to not make assumptions regarding a person's religious beliefs. Professionals must also be trained to be comfortable asking questions to gauge a client's willingness to accept a treatment that aligns with their beliefs, thereby increasing help seeking for Muslims by making them feel safe and supported. It should also be understood that there is still diversity within a religious group. Islam has many sects (i.e., Shia, Sunni, Ismaili) and each of them have slightly different

interpretations of Islam however differences in beliefs regarding mental health between different Islamic sects have not yet been investigated in the literature. Again, it is important for psychologists and counsellors to ask the individual about their beliefs and expectations of treatment and to not make assumptions regarding a client's religious beliefs.

According to the APA Stress and Trauma Toolkit for Treating Jewish Americans (n.d.), Jews are more comfortable receiving mental health care from counsellors who are Jews themselves. Overall, the toolkit suggests taking a screening of social and cultural history to better understand their client's beliefs by asking question such as, "How does your religion/culture create conflicts/stress for you?" and "Does your family identify with a specific religion/race/culture/ethnicity?". Generally, it is also suggested to avoid making assumptions and to ask questions if needed no matter how insignificant it may seem in order to build solid rapport. These suggestions may also be applied to Muslim communities as sharing their religious beliefs with a professional prior to discussing treatments may make it easier for them to openly speak about their problems and receive appropriate care while observing their faith.

Immigrants and Second-Generation

With Canada accepting a growing number of refugees and immigrants in the last decade ("Just the Facts: Asylum Claimants", 2019), it is important to assess whether appropriate action is being taken to ensure new Canadians have information about services that are available to them. Refugee and immigrant mental health is one major area that needs to be acknowledged. It is known that many refugees and immigrants suffer from trauma and PTSD (Blackmore et al., 2020), loneliness (Stick et al., 2021), and depression (Blackmore et al., 2020) before and after they arrive in a new country. In a survey of Kurdish and Afghan Muslim refugees living in Australia and New Zealand, the most common stressors reported included overthinking, feeling overwhelmed, relationships (e.g. family tension), cultural change, and social isolation (Sulaiman-Hill & Thompson, 2012). Furthermore, psychological distress in this population was much higher than the average among the general population in New Zealand and

Australia. Among refugees speaking minimal English, being female and being unemployed increases the risk of psychological distress (Sulaiman-Hill & Thompson, 2012). I assume refugees and immigrants are provided multilingual information booklets when they first enter Canada and that these pamphlets have a list of services they can access such as doctors and counsellors. However, the existence of such booklets is not confirmed nor denied on Government of Canada websites so I cannot know if this true. If such booklets are not provided to newcomers, then Canada should take action to provide information regarding employment centres, numbers to contact for physical and mental health care, and information on support groups for new Canadians. Even once immigrants settle down, they are less likely to be aware of social services in their communities since they did not grow up in that society (Simich et al., 2005). So, it is crucial for Canadian service providers to recognize the need for these services and to target their ads specifically to at-risk groups like immigrants, refugees, and second-generation Canadians and especially so towards women and children (Amri & Bemak, 2012). This will make at-risk Muslims feel more comfortable accessing services because they would become familiar with where and how they can seek help from reading such booklets.

Additionally, immigrants and second-generation Canadians may have trouble integrating their family beliefs into mainstream Canadian beliefs. It is known that cultural beliefs become a part of who someone is and shapes self-concept from a young age (Brown et al., 2009). For those who are not born in Canada, cultural beliefs from one's home country may follow individuals and influence the decisions they make as Canadians even if they have lived here for many years. Second-generation Canadians, although born here, grow up in households where their parents and close family members draw on cultural beliefs to make decisions for their children. These individuals may grow up not knowing about mental health services because their own parents did not access these services due to various barriers (Leão et al., 2007). The ecological systems theory framework seeks to understand the micro, meso, and macro interactions as a child develops (Guy-Evans, 2020). So, it can be used to analyze how culture and

religion interact when second-generation Canadians are growing in order to provide insight into areas that need more support (i.e., educational campaigns to raise awareness about services).

For those with a collectivist cultural background, it can be difficult to assimilate into an individualistic society like Canada. Individualistic and collectivist beliefs can influence help seeking behaviour. For one thing, mental illness among Jewish and South Asian cultures may be seen as something that affects the individual and their families (Yang & Pearson, 2002; Ali et al., 2004). An individual from a collectivist background, such as someone who is Muslim or an Orthodox Jew, is faced with a hard decision to make and they may feel they are being selfish or ungrateful towards their family if they choose to put themselves first. Finding a counsellor that is trained to provide culturally competent care is crucial here because they would better understand the thought-patterns and reasoning behind an individual's mental health needs (Sue et al., 2009). In this case, community-centred care and faith leaders are key to helping individuals find appropriate services and are discussed later in this paper. Individuals should not have to choose between multiple identities and it may be possible for several identities to peacefully coexist as long as appropriate services are available.

2 - Prioritizing Community-based Interventions

Religious Leaders

In Islam, each Muslim community has a faith leader they call an *imam*. Imams are a central part of the Muslim community, leading worship rituals and being trusted as guidance counsellors for religious matters due to their extensive education on Islamic studies and its rulings (Ali & Milstein, 2012). Considering their close spiritual relationship with congregants, *imams* are a great resource to confide in for health matters and for receiving counselling. Clergy members and other religious leaders are often the go-to person for religious folk when they need counselling or when they are feeling distressed (Wang et al., 2003). A survey of 62 American *imams* found that 50% spent one to five hours each week providing counseling and making mental health referrals, meaning *imams* are often providing mental

health counselling (Ali et al., 2005). In the UK, another survey of Muslim faith leaders consisting of *imams* and religious course graduates found that *imams* are a significant resource in the Muslim community for informal counselling and they have low stigma of mental health, making them approachable for mental health support (Meran & Mason, 2019). About 2/3 of surveyed *imams* have in the past referred congregants to a general practitioner and over half recommended them to a psychologist or psychiatrist (Meran & Mason, 2019).

How much training on mental health do *imams* currently receive? Not very much. *Imams* are only educated on religious rulings and most lack specialization to treat mental health concerns (Arefin, 2018). Surveyed *imams* in the US lack formal mental health training although there is a need for it and an openness among *imams* to learn how to support their congregants (Ali et al., 2005; Abu-Ras et al., 2008). In addition, 70% of those who gave feedback on the Khalil Centre's "Muslim Mental Health First Responder Training" said it was the first training of this nature they had every received while the other 30% had received training that was not Islamically or religiously focused (Syed et al., 2020). Considering how often *imams* are in contact with Muslims for mental health support and the lack of training they currently receive, there is a need for specialized training to support their role in the Muslim community. Religion shapes identity, thought patterns, and behaviours (Smith et al., 2016) so training on mental health in the context of religion can increase help seeking among Muslims.

Does this training work? In a survey of U.S. *imams'* perceptions of mental illness, there was a positive correlation between counselling training and likelihood of counselling congregants from the community, showing trained *imams* are more comfortable providing mental health counselling (Ali & Milstein, 2012). Furthermore, previous exposure to mental health professionals was also a factor that made *imams* more likely to make referrals to external supports (Milstein & Yali, 2010). It is therefore important for *imams* to be aware of external mental health services and to be comfortable making referrals and talking about mental health, this is where training can help. Additionally, community mental health initiatives and

organizations that specialize on Muslim and minority mental healthcare should actively work with mosques and *imams* to connect with the Muslim community.

When interviewed about their perceptions about depression and mental illness, religious leaders (i.e., *imams)* in Canada stressed the importance of communities supporting each other during times of need. They even believed it to be a religious obligation from God to do so, highlighting the commonly held belief that Muslims are obligated to help each other when they are unwell – when one member of the community is ill the others should emphasize and help out as best they can. Surveyed *imams* also mentioned that in addition to community and external supports, Muslims should connect with their faith to find spiritual healing and support through prayer and reading the *Qur'an* (the holy book of Islam). For instance, *imams* believe counselling and pharmaceutical drugs are appropriate for treating depression, however they are insufficient alone and should be taken alongside spiritual healing practices such as prayer (Tobah, 2018). This shows that *imams* are open to talking about mental health and accept receiving treatment for it. It also highlights the delicate balance required between traditional care and non-traditional religious care. To emphasize, if *imams* are not trained to detect distress in congregants and to make referrals to external organizations, following this balanced model of mental health care is impossible. Due to the deep bond between *imams* and Muslims, referrals made by faith leaders would likely be accepted and followed through especially if the *imam* can convince the individual that doing so does not go against Islam. This again highlights how training can be beneficial in supporting *imams* which in hand increases help seeking among Muslims. Training would not only benefit communities in lowering stereotypes about mental health but it would also enable *imams* to make referrals for individuals to actively seek help from qualified professionals.

Is it possible to change stereotypes about accessing mental health care for Muslims? One can take lessons from a study done on Jewish communities as these two religious minority groups are both hesitant to do things that may go against their beliefs (e.g. access certain types of healthcare). A follow-

up to a study conducted 25 years ago on a Jewish Orthodox community in the United States found that there was a general decrease in stigma surrounding mental illness but no change in stigma for seeking mental health care (Schnall et al., 2014). The authors suggest that more training in mental health care among clergymen (i.e., *rabbis*) would benefit the community and increase help seeking behaviours (Schnall et al., 2014). Again, this re-emphasizes the importance of training religious community and faith leaders to support their communities for mental health concerns.

What would training for *imams* look like? An example of mental health training for *imams* is the "Muslim Mental Health First Responder Training" which has been run by the Khalil Centre since 2016 (Syed et al., 2020). These sessions are attended by Islamic clergy and community leaders and guides attendees through identifying and responding to mental health concerns from an Islamic context. Surveys were distributed to about 500 workshop attendees across cities in the USA and also in Toronto, Canada between 2016 and 2018. 92% of respondents said they would recommend this training to others and 88% indicated they would do further training if it was offered. All respondents believed their understanding of mental health improved after this training and most had never done any previous mental health training (Syed et al., 2020). Feedback from these sessions shows the need for such trainings and the positive impact it can have on increasing awareness among Muslim faith leaders, helping them become more comfortable speaking about mental health.

Overall, following the Khalil Centre's model *imams* and community leaders in the Muslim community need to be trained to identify when someone is in distress. They also need to know which services are appropriate for an individual and this is where external organizations can help. It may be easier for external organizations to reach out to Islamic institutions in the community such as mosques and schools to allow *imams* and Muslims to become familiar with the types of services provided (i.e., hotlines, walk-in appointments, costs, locations). This would support *imams* because they may be unsure of how to access or contact these service agencies on their own (Tobah, 2018). Lastly, religious

leaders can learn techniques from trainings to facilitate discussions that would help Muslims open up about their problems, allowing faith leaders to make appropriate referrals.

Limitations

Although the goal of this review was to find information on help seeking initiatives that have been successful among Jewish and South Asian minorities in western contexts, little information was found due to the strict timelines of this project. Furthermore, intersectionality has been established in this paper as having a significant impact on help seeking. Since many Canadian Muslims have a South Asian background, it would be useful to understand how being both South Asian Canadian and Muslim influences the likelihood of help seeking to try and understand how to improve service access for this niche. Additionally, it is clear that Muslims in Canada come from diverse backgrounds and thus, seeing how culture and religion interact through an ecological systems theory lens would enable an understanding of help seeking from macro, meso, and micro perspectives. Furthermore, this review was focused more so on the impacts of help seeking on the individual level. For many people, especially those from Eastern backgrounds (i.e., collectivist), health impacts not only the individual but also families (Gopalkrishnan, 2018; Pyke & Bengtson, 1996). It would be useful to consider whether there are family-centred services and how one may increase help seeking through such means. Lastly, the views of this paper are a reflection of western perspectives. It is very plausible that Muslim Canadians feel more comfortable seeking traditional care for perceived mental illnesses instead of seeking a counsellor or pharmaceutical intervention.

Conclusion

The recommendations coming out of this project can be used to address stigma and discrimination from mental healthcare providers and community members to inform approaches to increase help seeking for Muslim Canadians. Several important lessons on how to increase help seeking have been highlighted from a review of literature on South Asian and Jewish minority groups in western contexts.

Canadian Muslims have very diverse religious and cultural backgrounds and there is not one single solution that would help all members. However, there is a general consensus that the focus should not necessarily be to create new methods that are culturally appropriate, rather more time should be spent learning from Muslim Canadians and the communities themselves on how they want to access mental health services. Additionally, any interventions on improving help seeking should account for the heterogeneity among Muslims in Canada (Amri & Bemak, 2012). Equally important is the idea of training and empowering religious leaders to support the Muslim community. Given that religious leaders *(imams)* play a significant role in counselling Muslims, it is crucial to train them on how to identify and support the mental health needs of Muslims. In this regard, the Khalil Centre's training approach for faith leaders is one successful example and has been proven successfully in educating *imams* on how to effectively counsel Muslims in alignment with Islamic beliefs. Additionally, external organizations that may not necessarily be Muslim can support Muslim minorities in Canada by connecting with community hubs (i.e., mosques) to showcase the services they provide. Finally, The APA Stress and Trauma Toolkit for Treating Jewish Americans in a Changing Political and Social Environment suggests that mental health professionals should be mindful of implicit biases when working with diverse clientele and should also be trained to provide culturally competent care. Professionals should ask screening questions like, "Does your family identify with a specific religion/race/culture/ethnicity?" to better understand their client's beliefs prior to beginning treatment. Following these principles are critical to building rapport with Muslim clients, enabling Muslims in Canada to receive appropriate and inclusive care. Ultimately, this research serves as a starting point to inform mental health research in Canadian Muslim communities to increase help seeking, allowing Muslims to receive equitable, evidence-based, and appropriate mental health care in an accessible manner.

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