Constructing Mental Illness: Comparing Discourses on Mental Health, Illness, and Depression by Muslim Leaders with those found in Consumer Health Materials

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Abstract

The purpose of this research was to investigate the information landscape regarding mental health, mental illness, and depression as Muslim immigrants in a mid-size Ontario city might encounter it. This was intended as a microstudy exploratory project using a constructionist qualitative approach. A discourse analysis was conducted on a small sample of collected ‘texts’ (pamphlets and transcripts of interviews with Muslim religious leaders). The pamphlet content reflects a primarily medicalized construction of mental illness and depression whereas religious leaders, while recognizing the possible need for medical intervention to deal with mental health problems, focused on the significance of overcoming social isolation. Religious leaders emphasized the community’s responsibility in supporting those suffering from depression and mental illness. This diverged from the individualized narrative presented in the pamphlets and presented a communal approach to health.

Keywords: Health Information, Mental Health, Depression, Immigrants, Islam, Imam
Canada is home to many Muslim immigrants. Most recently, the Syrian refugee crisis has precipitated the Canadian government to welcome over 40,000 refugees as of the end of January 2017 (Government of Canada, 2017). According to the 2011 census, of a population of just above one million Muslims in Canada, over 700,000 are immigrants, the majority of which reside in Ontario (Statistics Canada, 2017).

The migration process can cause a great deal of insecurity and trauma for immigrants and refugees causing a need for mental health support. The contributing causes include exposure to violence before and during migration, as well as insecurities related to resettlement (Kirmayer et al., 2011). Loss of social status, difficulties learning new languages and social norms, as well as the loss of social supports are all factors that bring additional stress to their lives (Kirmayer et al., 2011). Fear of stigma and further social isolation may prevent immigrants from seeking help from healthcare professionals (Wood & Newbold, 2012). Despite the reported need for mental health services, immigrant populations often face many barriers in receiving the necessary assistance (Fawzi et al., 2009). Mental health service providers may encounter challenges in providing services to new immigrants. In addition to possible language barriers, various cultures may express moods differently and manifest health and illness in different ways, making it difficult to diagnose particular conditions (Neale & Wand, 2013; Stolovy, Levy, Doron, & Melamed, 2012). Amer and Hovey (2007) define acculturation as the cultural change that occurs as a result of continuous interaction between two different cultural groups, and describe the process as a potential and significant source of stress, as new immigrants are faced with learning a new language, adopting new customs, learning new laws, and experiencing incidents of perceived discrimination. These cultural aspects intersect with socioeconomic conditions as well as dominant structural factors, such as racism, gender roles, and xenophobic sentiments, predisposing immigrant groups to poor mental health (Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

A systematic review conducted in 2013 (Walpole, McMillan, House, Cottrell, & Mir, 2013) identified many factors that may be considered when treating Muslim patients for depression including religious and cultural perception on mental illness. For example, some study participants believed that mental illness had spiritual causes (like lack of religiosity) and thus can also be cured through obedience to God. Furthermore, many studies discussed Muslim patients’ preferences of seeking help from a therapist at least familiar with their traditions if not Muslim as well. Another study exploring the role of imams in the mental health of American Muslims (Padela, Killawi, Heisler, Demonner, & Fetters, 2011) found that imams have a role in framing health information for congregants as well as in health care settings for non-Muslim practitioners. The work of Ali and Milstein (2012) also brings forward the roles of imams in
referring congregants to clinicians, while continuing their own counseling, to provide a collaborative, culturally sensitive approach to mental health.

The purpose of this microstudy is to explore the information landscape related to mental health, mental illness, and depression as it pertains specifically to Muslim immigrants through the comparison of discourses presented by Muslim leaders and those found in information literature intended for the lay public. This comparison is intended to highlight the similarities and differences between the discourses invoked when discussing depression, demonstrating the array of messages about mental health and illness that may reach Muslim immigrants. The project's small-scale comparison identifies and explores the information landscape that Muslim immigrants and refugees are likely to encounter when dealing with emotional challenges and mental health issues, particularly those that arise during the process of immigration and settlement.

Methods

Data Collection

This study was intended as a small-scale project in order to identify areas of possible further exploration. For the purposes of this research, 'leaders' in the Muslim community are individuals who 1) hold the position of imam and/or are chosen to conduct its duties on behalf of the mosque or 2) are teachers of a circle of religious knowledge (colloquially known as a halaqa) in one of the Muslim institutions in the city. These categories of leaders were chosen to allow for both male and female participants as well as the inclusion of individuals who do not hold the main leadership position of imam but still have the opportunity to share their impressions and knowledge with the Muslim community. Possible participants were identified through the institutions’ community newsletters and email alerts that named those functioning in the described roles as 'leaders'. Interviews were conducted using a qualitative constructionist approach (Potter & Hepburn, 2008). A total of eight participants were interviewed for the purposes of this study, five men and three women. Interviews were conducted in English. Seven of eight participants consented to the interview being recorded. Detailed notes were taken during the non-recorded interview instead. The study design was approved by the University of Western Ontario's Non-Medical Research Ethics Board.

The constructions of mental health and depression that are revealed through the analysis of the interviews were subsequently compared to those found in lay consumer health materials concerning mental health and depression. These materials were obtained from organizations that provide service to immigrant populations such as public libraries, walk-in clinics, health units,
and cultural learning centers. Because immigrants are often dealing with unfamiliar information environments and are trying to navigate everyday information needs, there is likely to be considerable fluidity between deliberate and unconscious information-collecting practices (Caidi, Allard, & Quirke, 2010). As a result, the pamphlets were collected based on availability in the identified city centers. In order to be included in this project, the pamphlets needed to address mental health, depression, emotional wellbeing, or how to receive help for issues related to mental health. Pamphlets that only described an institution and the services offered through that institution were excluded. Although beneficial in another context, these pamphlets did not provide an understanding of mental health and depression that could be included in the analysis conducted in this project. Five pamphlets total were collected. Three pamphlets were produced by a national mental health organization with local presence, one was produced by an organization that specifically seeks to inform immigrants on issues of mental illness and addiction. The last pamphlet was produced by a local family support services organization.

Data Analysis

The small sample allowed for the analysis of qualitative data to occur simultaneously with the data collection. This not only allowed for further clarification as necessary, but also permitted emerging themes to inform subsequent questioning (Bowen, 2009). Once collected, the interviews were transcribed immediately. The collected texts (transcripts and collected pamphlets) were analyzed in two ways: The first was a thematic analysis involved a thorough reading of the texts to identify repeated themes and ideas, and these were highlighted and collected into codes (Bowen, 2009). The second was a predetermined framework of questions, which was used to deconstruct the emerging discourses (Rudman, Huot, & Dennhardt, 2009). Ballinger & Payne (2000) quote Potter and Wetherell (1995, p. 80-81) describing a discourse analysis as being “concerned with what people do with their talk and writing . . . and also with the sorts of resources that people draw on in the course of those practices”. In the analysis of both the text of the pamphlets and the interviews, attention was paid to the words used to describe mental health, mental illness, and depression, along with the context and resources that are called upon in the process of this description. The thematic analysis conducted combined with the predetermined framework were both used in order to try to answer the question of trustworthiness (or credibility; Fereday & Muir-Cochrane, 2006).
Results

Pamphlets

The pamphlets generally reflected a biomedical perspective on mental health, illness, and depression. Descriptions of symptoms, causes, treatment, and prevention offered parallels to physical health, means of evaluation, and support options.

A pamphlet listed the main symptoms of depression as including feelings of worthlessness, sadness, anxiety, and/or loss of focus that affect day-to-day functionality that persist for more than a few weeks. Another pamphlet also included similar list of symptoms, further addressing immigrants and refugees by stating that, “feeling sad or worried are normal reactions to living in a new country. It is a good idea to ask for help if you feel this way for more than a few weeks.” This statement differentiates between the ‘normal’ feelings associated with the stresses of immigration and the ‘non-normal’ state associated with a mental illness. The focus on the length of time one experiences a symptom reiterates the difference between the normal and non-normal. In this case, “a few weeks” is deemed the cut-off point at which an individual who experiences symptoms should reach out for help.

The causes of mental health problems were described primarily as a result of chemical imbalances, genetic predisposition, or a family history of depression. Socioeconomic factors were highlighted as further affecting the manifestation of mental illness in its onset and possible relapse. It was emphasized that mental illness is akin to physical illness and should be viewed in the same way in terms of causation and possible treatment. One of the pamphlets stated, “You would not hesitate to go to your doctor for a broken leg; seeking help for depression is no different.” This message is also reinforced through the comparison with physical illness, suggesting that both types of illnesses should be the seen the same way. In other words, they involve different realms of the body but are primarily internally caused and can be diagnosed, treated, and prevented in the same way.

The most common treatments listed for all mental illness involve pharmaceuticals and a form of counseling. The pamphlets advised affected individuals to contact a family doctor, self-refer to a psychologist, and/or approach a community organization. It is also often stated throughout the pamphlets that familial, social, and community support are all important parts of the recovery process. A pamphlet stated that “a supportive network of friends and family is also very helpful.” In this context social support is viewed as assisting with the treatment but is not part of the treatment itself.

In the biomedical presentation of depression and mental illness, it is the individual who is diagnosed and treated. It is also the individual who must take
personal measures to prevent or mitigate the effects of mental illness. Some of the preventative measures suggested in the pamphlets include self-education, regular exercise, good nutrition, and stress management. Self-education is commonly featured in the pamphlets. It is presented as a preventative measure and assumes that by informing individuals about the symptoms and treatments for mental illness readers can mitigate its effects. A pamphlet on depression and bipolar disorder describes encouraging the reader to learn about mood disorders by using library resources and community educational opportunities as “bibliotherapy”. The reader is encouraged to learn about mental illness by visiting the library, community health organizations, and reputable online sites as a mechanism of prevention.

**Dominant Discursive Constructions**

The five pamphlets all offer a similar medicalized narrative with respect to the symptoms, causes, and treatments of depression, constructing mental illness as analogous to a physical illness. While social and environmental factors are recognized in the pamphlets as affecting an individual’s mental wellbeing, genetic and physiological causes for mental illness are heavily emphasized and, relatedly, the use of pharmaceuticals combined with counseling by a health professional is described as the most effective form of treatment. Thus, the problematization of mental illness/poor mental health focuses on dysfunctional or deficient mind and body systems, which are unable to maintain health in the face of particularly stressful environmental factors. Solutions also focus on ‘fixing’ or regulating mind and body systems, thereby making an individual more capable of maintaining mental health in his or her contextual conditions. Beyond the need to address stigma, the pamphlets say little about ways of changing environments so that they promote or enable mental health. Instead, individual responsibility on the part of the person experiencing poor mental health is emphasized, such as taking preventative measures to inhibit the onset of mental illness.

In the one pamphlet which is intended for an immigrant audience, there was no direct mention of the acculturation process, only that new immigrants may feel anxious and unsettled for a few weeks after their arrival. The sources of authority mentioned in the pamphlets with respect to managing mental illnesses reiterate a medicalized understanding as these ‘experts’ are identified as doctors, psychologists, psychiatrists, and other healthcare workers. The discourse presented in the pamphlets is also individualistic as it is the reader who is encouraged to play an active preventative role by modifying personal behaviors and learning more about mental illnesses. Furthermore, it is the individual who is repeatedly encouraged to reach out for help and ask for assistance when feeling overwhelmed, depressed, suicidal, or in need of support. While friends and fam-
ily are encouraged to ask after loved ones, no mention is made of ideas of collective responsibility for mental wellbeing. This centers the focus on the individual's role in the prevention, treatment, and management of mental illness.

Interviews

Signs identifying mental illness and depression

The interviewees mentioned a number of indicators that flag potential mental health issues that require additional support beyond their own active listening and religious counseling. Many of these indicators were externally visible, obvious signs and require no training to recognize that an individual is in need of specialized attention. For instance,

[When] someone's standing beside you talking to another person that they think exists, that is a strong, like, you can't deny something like that. (participant 2)

Another sign of ill health identified by the participants is when the people who approach them consistently express negative attitudes and/or lack of hope.

I feel like for me there's indicators of bad state and what I tend to see is that they, they don't have much hope. They're not . . . they've become disinterested in certain things in life. They . . . you know, the way that they're talking is almost monotone . . . you know, detached. It's not so much about solutions anymore. Those are things that I find very concerning. (participant 2)

When such ‘flags’ are not identifiable externally, through the behaviors of the individual, there are other warning signs that can be indicators of mental illness, the most notable being distress in the family.

So they may not talk about it but it may be manifested in what is called domestic problems. So problems would arise between husband and wife, between children and parents. (participant 3)

A distinction made by some of the interviewees is that not every emotionally unstable state is an indication of a mental illness. For instance, a person may experience a period of sadness or hardship but this state is transient and not a sign of unhealthiness. Such emotional instability may be a result of a death or, in the case of immigrants, a new environment. As long as the disturbed mood state is temporary, it is not necessarily an indication of ill health.
Not every failure to cope with such a stressor is an indication of mental illness. (participant 3)

Overall, the interviewees described the symptoms of mental illness as obvious, prolonged, extreme, and where the behavior of the individual is clearly differentiated from what is considered to be ‘normal.’ For all eight interviewees, these extreme instances are ones for which they suggest that another party should be contacted, one who is separate from the religious institution and can offer the necessary support. The external party was not specified as a medical professional but just someone external to the affiliated religious institution, such as providers of counseling and social services.

**Understanding why mental illness and depression happen**

The interviewees discussed causes for mental illness and depression that include factors both internal and external to the individual. Neither of these types of causes were described as being controllable by afflicted individuals or are considered to be their fault. The internal causes mentioned included chemical imbalances in the brain, reflecting a biomedical understanding on the part of the interviewees. In describing the nature of mental illness, some interviewees made a comparison to physical illness as a way of explaining the individual does not have control over his/her state of illness.

It’s like saying you shouldn’t have cancer. Well I would love not to have cancer, I would love not to be depressed, and I think that’s really where the issue comes in. (participant 2)

However, not all of the religious leaders agreed with a complete parallel between the mental and physical spheres.

If you have a headache, you know what you’re gonna take, stomachache then you know what you’re gonna take. This is, this is something that it is visible to the doctors and they can, and they can diagnose what you have and they can give you the medication accordingly. But the issue with the emotional suffering or the emotional illness is something related to the personal life, personal experience. It’s very difficult to get into that sometimes. (participant 1)

The interviewees who distinguished between mental and physical health often linked mental illness to external factors; environmental and societal, often relating to the condition of immigration. For instance, they described isolation as one of the potential causes, particularly of depression. Immigrants were de-
scribed as finding themselves isolated as a result of their dislocation; no longer connected to family and friends, no longer comfortable in their surroundings, and perhaps having trouble communicating in an unfamiliar language.

[We] try to explore together if it’s evident that they’re spending a lot of time alone. That they haven’t, you know, that haven’t made new connections with people. What might be stopping them from doing that is it language? Is it cultural, have they had negative encounters, is it the perception of others? (participant 7)

The conditions of migration were also cited as affecting the mental wellbeing of immigrants, particularly with respect to refugees and those who emigrated from war-torn countries, possibly having witnessed trauma. Furthermore, fleeing in a state of fear was described as creating significant stress, affecting mental wellbeing as well as the ability to recover through reestablishing positive relationships in Canada.

**Addressing mental illness and depression**

When asked directly about the use of pharmaceuticals and/or counseling to treat depression, all of the interviewees agreed that these are appropriate treatment methods. However, a few noted that, in their opinion, this approach misses other supports that can be of use to a person experiencing mental health problems. One of their concerns is whether counselors offering professional psychological services will be sensitive to the religious practices of Muslim individuals and, perhaps, encourage behavior or philosophical positions that are against Islamic teachings. Another aspect that the religious leaders think may be missing from ‘mainstream’ mental health treatment is encouraging socialization in order to help the recovery process. This was described as a process that cannot be provided by a therapist or a doctor. This also led to comments about the role of the community in this process. In particular, some interviewees stressed that it is not just the individual who is responsible for his/her own wellbeing, but rather the community that should be of assistance where possible. Another interviewee invoked this community responsibility as a religious one, stating that it is God that encourages this behavior.

Allah (God) wants us to help each other. There are sick people, we are responsible for them if we are healthy. There are poor people, we are responsible for them if we are rich and so on and so forth so that we live together on this earth working righteousness only, staying away from evil. (participant 5)
In addition to social and medical treatments, the interviewees also mentioned the use of religious practices such as prayer, to help the depressed individual. A few interviewees referred to religious practices of prayer and reading Qur’an, not necessarily as a treatment for mental illness, but as a method of support for individuals undergoing difficult times, as well as for maintaining mental health. This was noted as part of the belief system of individuals who are requesting help. Since they are reaching out to a religious community leader, it is likely that help-seekers perceive their problem, and thus its solution, to be based in religion as well.

**Dominant Discursive Constructions**

The interviewees presented a narrative that differs in many respects from that found in the pamphlets. Although elements of the dominant biomedical discourse, as exemplified in the analysis of the pamphlets above, were taken up within the construction of mental illness and depression conveyed by the religious leaders, the leaders’ understandings included more explicit attention to environmental factors that can create overwhelming burdens which may result in a person becoming off-balanced and lead to depression. All of the interviewees agreed that the use of pharmaceuticals and counseling are appropriate methods of treating depression, however many added the qualifier that these methods were insufficient. Given the discursive expansion of causative factors to include environmental stressors, solutions offered by the religious leaders extended beyond medical treatment to address social issues.

Many interviewees noted isolation as potentially having a great effect on mental wellbeing, particularly for new immigrants who are not familiar with their physical or social surroundings. The religious leaders commented on their ability to assist with no more than the spiritual and social aspects of congregants’ mental problems, recognizing that they are not trained as counselors, hence the need for external assistance. Most interestingly, one interviewee stated that the responsibility to assist those afflicted with mental illness is an Islamic duty of anyone who is healthy in the rest of the Muslim community. The discourses presented by the interviewees who discussed collective responsibility differed from the individualized focus that was evident in the pamphlets. Instead of emphasizing the individual’s role in seeking help, the religious leaders point out that it is the healthy members of the community who must take action to ensure the wellbeing of the ill. The interviewees also discussed religiosity in the context of providing spiritual support for individuals who are experiencing difficulties, however, they did not attribute mental illness to individuals’ lack of religious practice.
Discussion

Understanding Classifications

In Sorting Things Out: Classification and Its Consequences, Bowker and Star (1999) encourage the examination of classification systems, arguing that such systems are “artifacts embodying moral and aesthetic choices that in turn craft people’s identities, aspirations and dignity” (p. 4). Classification systems are the underlying structures that simultaneously support or make visible certain understandings of phenomena while concealing others. In the case of mental illness, standard medical classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), not only differentiate between various types of illnesses but also between ‘ill’ and ‘normal’ behavior. Crowe (2000) conducted a discourse analysis to examine the DSM-4 stating that the diagnostic manual constructs the concept of normality through the definition and designation of various mental illnesses. He also asserted that such a classification system is built from underlying socio-cultural assumptions that need to be scrutinized in order to understand how ‘normality’ is constructed and defined. In the pamphlets examined, depression is classified as a mental illness and differentiated from regular or ‘normal’ emotional reactions to experiences such as bereavement. The classification used in the pamphlets is consistent with the DSM-5, which lists depression, describes its symptoms, and explains how it is diagnosed and distinguished from a less intense state of ‘low mood’. The pamphlet specifically divides mental illnesses into various types, including mood disorders, anxiety disorders, eating disorders, personality disorders, and others. Here, depression is classified as a mood disorder. In contrast, the ways in which Muslim community leaders ‘classify’ mental illness was rather different. Importantly, some interviewees were reluctant to take up a medical discourse when discussing depression, yet they still acknowledged that in some instances there might be a need for medical attention.

The question that helped elicit how the religious leaders internally classify or make sense of depression was they were asked to describe healthy and unhealthy emotional states. By invoking the discourse of health, interviewees were being asked how they relate moods to concepts of health and wellness. Their replies revealed that they make a distinction between unhealthy behaviors and illness in that an individual can engage in unhealthy behavior or be in an unhealthy emotional state without being ‘ill’. The religious leaders classified individuals who sought their assistance by distinguishing between positive and negative behaviors. However, they recognize the context in which such behaviors occurred, addressing that context as a possible cause of the exhibited behavior. In addition, the religious leaders classified individuals depending on...
whether or not they could offer them assistance or if the situation required additional expertise.

Recognizing the Presence of Mental Illness and Depression

One of the key differences between the constructions of mental health found in the pamphlets and the interviews is that the interviewees emphasized externalized behaviors or attitudes that can be observed and compared to normative social behaviors. Because the Muslim leaders interact with community members in a social capacity, these external ‘symptoms’, such as erratic behaviors, are more obvious and easier to detect than the internal symptoms described in the pamphlets. In the pamphlets, various personal symptoms of mental health problems were highlighted, including behavioral changes such as changes in appetite, energy levels, sleep, and the ability to focus, as well as feelings of hopelessness, stress, fear, and anxiety. Some of these symptoms were also described in the interviews, particularly a consistently negative attitude and feeling hopeless, but the religious leaders tended to emphasize more externalized or ‘visible’ symptoms, such as erratic behavior, strange speech patterns and body movements, as well as talking with people who are not present. The interviewees also mentioned physically or psychologically harmful behavior to one’s self or others as an indicator of a state of crisis that requires specialized care.

Although the symptoms emphasized in the pamphlets and the interviews differ, the duration and intensity of symptoms are discussed in both as indicators of when a problem requires closer examination. Specifically, both the pamphlets and the religious leaders emphasize that ‘low mood’ over a long period of time that negatively affects quality of life is not normal and is a sign that the affected individual is in need of assistance. Some of the symptoms described, such as feeling worried, stressed, fearful, angry or aggressive, are viewed as to be expected in people who are undergoing many life changes, as is the case for recent immigrants. A pamphlet suggested that while these feelings may be normal for an immigrant, help should be sought if these feelings persist for more than a few weeks. One of the interviewees described a similar scenario but suggested that help should be sought if the feelings persist for six months, raising an interesting question about how long it should be considered ‘normal’ for an immigrant to feel worried, stressed, and fearful after settling in Canada.

Understanding Why Mental Illness and Depression Happen

An important difference between the pamphlets and the interviews emerged regarding the causes of mental illness, particularly depression. Overall, the religious leaders tended to focus on environmental causes whereas the pamphlets, while referring to environmental factors, focused more on biomedic-
conclusiveness. One interesting discrepancy between the perspectives presented in the pamphlets and the interviews was with respect to the role of families. The pamphlets describe the role of the family as a support system during the treatment process, whereas the interviewees discussed family dynamics as a source of stress for new immigrants as well as a potential cause of depression. This significant discrepancy over the role of family as a stressor or a source of support demonstrates how some of the underlying assumptions made in the pamphlets could be problematic. The pamphlets indicate that family members may be included in therapy sessions to both support someone with a mental illness and, in turn, benefit themselves from therapy. The assumption that is made in this case is that family members are willing and available to play a supportive role. The examples provided by the interviewees demonstrate why such assumptions are problematic. Indeed, many interviewees discussed domestic issues as problems for which immigrant Muslim community members would seek assistance. These observations are consistent with the writings of Carlos Sluzki (1979) who relates the migration process to family conflict. Whether the migration was forced or a matter of choice, legal or illegal, the family is severed from the usual social support networks. As a result of the migration process, the immediate environment is no longer predictable and family roles are in flux in reaction to the new host culture (Sluzki, 1979). Here, families can become a source of conflict rather than support. Many of the religious leaders cited domestic problems as either a source of personal stress that causes poor mental health, or a reflection of an individual who is struggling with mental health.

The interviewees suggested that spiritual practices can improve an individual’s mood and be a source of support during times of difficulty. However, the interviewees did not list lack of religious adherence as a cause of mental illness or depression. The interviewees did not discuss failure to adhere to religious practices as a cause of poor mental health, but rather framed religious practices as a way of maintaining good mental health, in that they can provide coping mechanisms as well as cognitive supports that may help to alleviate stress and low mood. It is also noteworthy that, other than to include clergy members as potential sources of referral, none of the pamphlets examined mentioned the role of faith in relation to depression or mental illness.

Addressing Mental Illness and Depression

Of the eight religious leaders interviewed, many indicated that the problems with which they are approached by members of the community may require the intervention of a trained professional (although they didn’t necessarily specify the need for a physician). In other words, without necessarily medicalizing the problem, they perceive that a more trained and qualified individual may be needed to deal with the situation. The sources of authority that the in-
terviewees said they would call upon if someone exhibited symptoms related to depression also illustrates the way in which they classify depression. Even those who mentioned the involvement of a physician discussed the social aspects of depression and the impact of socialization on treatment. This suggests perhaps that they did not find that the designation of depression as a mental illness to be mutually exclusive with its classification as a social ailment as well. If this is the case then the suggested implication is that illnesses are not solely rooted in the individual, requiring an understanding that is not solely medicalized but one which also recognizes the importance of societal involvement in the treatment and prevention of illnesses. When directly asked about a medical approach to the treatment of depression, none of the religious leaders refuted the possible necessity of the use of pharmaceuticals. However, many of them were explicit in their views that a medicalized approach to the treatment of depression alone was insufficient and that other supports are required to fully rehabilitate individuals who experience such problems.

The religious leaders were reluctant to label themselves as sources of authority on issues of mental health, stating that their knowledge was more limited to religious and spiritual support. This is similar to the findings of Ali and Milstein (2012), that American imams recognize the limitations of their abilities and know when an individual is in need of mental health support. Interestingly, many of the interviewees brought forward the unique voices, experiences, and needs of those that approach them for help rather than expressing a single narrative. This reinforced the perspective that rather than a single systematic biomedical treatment being appropriate for all cases, treatment should be dependent on the individual circumstances and environmental context experienced by the individual.

The interviewees see value in trying to change an individual’s mind set by using Islamic teachings, such as thankfulness (e.g., Thomas & Ashraf, 2011), or recognizing one’s blessings and thereby moving away from a state of overwhelming sadness. This form of assistance was considered to be useful to both those suffering from depression as well as those experiencing temporary low mood. The interviews indicate that such an approach was commonplace in the ways in which the religious leaders advise help seekers. These practices were discussed in the context of continued support for an individual who is struggling rather than as a course of treatment. This again reinforces previous work (Ali & Milstein, 2012) that found imams would like to continue to support individuals through religious practices, supplementing medical referrals. Importantly, the interviewees did not situate religious practices as an alternative to other treatment options. One interviewee went so far as to insist that it was not part of his role to state if an individual’s mental anguish was related to their religiosity (or lack thereof). This cannot be a factor, he explained, that a reli-
gious leader can dictate. As a result, it cannot be part of a religious leader’s role to prescribe a spiritual treatment for an illness.

Prevention

The interviewees had little to say about prevention of mental illness. Although some of them discussed ways in which an individual could maintain positive mental health, they did not suggest that a failure to take such actions would lead to a poor mental state. These actions included religious practices as well as engaging and contributing to the community in a constructive manner (such engagement can also assist with preventing the problem of isolation). One interviewee described the ebbs and flows of life as a series of highs and lows, suggesting that an individual can prepare for the lows but not prevent them from happening altogether. This is consistent with the religious leaders’ emphasis on environmental factors to explain mental health problems. As they are external to the individual, they are difficult to predict, prevent, or control. This perspective differs somewhat from that presented in the pamphlets which focused on personal behaviors that individuals can adopt to prevent the onset of mental illness, such as physical activity, good nutrition, and self-education. This differs considerably from the narrative that emerged in the interviews in which the religious leaders’ discussed at length the socialization and interactive practices that can improve an individual’s mental health, and their emphasis on the community’s responsibility to assist those who are struggling with their health.

Through the discussion on prevention in the pamphlets, the emphasis on individualism in biomedical discourse becomes apparent. As Donnelly and Long (2003) state, “the dominant biomedical discourse produces and validates knowledge that values rationality, and this knowledge influences the discursive attitudes of health care, which favors naturalism, individualism, and objectivism, while marginalizing other ways of knowing or assessing experience” (p. 401). This means that the basis of knowledge production in the biomedical paradigm is empirical rationalism that views the human body as a series of chemical interactions. Thus in order to treat or prevent illnesses, those chemical interactions need to be addressed. The individualistic focus in the pamphlets is also evident in the emphasis on personal behaviors, a reflection of the biomedical discourse which relies on individuals to modify their behavior in accordance (Donnelly & Long, 2003).

Information Mediation

It is suggested through this project that Muslim leaders could play the role of mediators or intermediaries by either contextualizing or simply transferring
information for congregants (Wayatt, Harris, & Wathen, 2008). Although the process of information mediation was understood to be one in which religious leaders convey health information to congregants and community members, the interviews suggest that health information is more likely to move in the other direction, from the Muslim community leaders to health professionals. Many interviewees discussed their lack of medical or psychological training and their discomfort with labeling their interactions with community members as ‘counseling’ and they consistently mentioned at what point they would refer an individual to a more qualified professional. Many of the interviewees had established contacts with organizations or individuals that could provide assistance. In these cases, rather than passing along medical information to congregants, the interviewees play the role of mediators by presenting the situation of the community member needing assistance to the contacted professional and describing the factors that may be involved. This could include the conditions of immigration or the individual’s current financial or familial situation. One interviewee specifically mentioned that he spends time educating teachers and school administrators about the difficulties students may encounter as new immigrants.

While the interviewees constructed their roles as separate from the medical paradigm, perhaps preventing them from providing specialized health information, there is still space for religious leaders to play a mediating role for congregants. As some of the religious leaders mentioned, they have been approached by individuals who believe that mental illness is both caused by and treated through religious practices. In such cases, the leaders may have the opportunity to act as mediators by molding such beliefs in a way that understands biomedical or social narratives of mental illness. This project is also based on the premise that religious leaders have the platform to shape community members’ perceptions on various issues through sermons and other forums. As a result, religious leaders can act also as mediators to the community at large by shaping perceptions of mental illness and dispelling associated stigma.

Study Limitations

For the purposes of this project, eight Muslim community leaders in one mid-size Ontario city were interviewed and their constructions of the meaning of mental illness, particularly depression, as well as its causes and treatments were compared with those presented in a small sample of pamphlets about mental health intended for a lay audience, produced by local and national organizations. While this small, limited sample allowed for a preliminary investigation, there is much room left for further inquiry. Time constraints prevented from further data collection. An additional limitation of this project was that the author was sitting on the board of a local mosque at the beginning this project.
If this was not the case, another individual could have also been interviewed. Snowball sampling would have also been a useful technique to enlist more interviewees. Snowball sampling may have also led to less publicly visible Muslim leaders, i.e., those who are not mams or halaqa leaders, who may be consulted about mental health concerns by members of the Muslim community.

Conclusion

This study presents important and relevant information that could better inform care for immigrant Muslims. It also highlights the gap in the literature describing the information landscape concerning mental health that is likely to be encountered by immigrant Muslims to Canada. This is an important and notable gap as, in order to better serve this population, it is important to know what understandings are pervasive and accepted within this community and how religion and religious authorities contribute to the health information landscape. While health and spirituality may not always be recognized as part of the same paradigm in the biomedical understanding of health, this research suggests that within the Muslim cultural community, it might be. Furthermore, immigrants who primarily identify with and seek help through the Islamic centers may be more accepting of a presentation of health that incorporates a religious understanding. In a future study, it would be worthwhile to investigate how Muslim immigrants seek and integrate health information with their own beliefs of health and illness as well as what contradictions may arise in these interactions and how they may navigate such contradictions.

This study also highlights the possibility for partnership between religious and social institutions that provide support for Muslim immigrant populations. While some organizations already reach out to the Muslim community in order to better understand the needs of immigrants who use their services, such relationships could be deepened to include other relevant service providers. While this provides a significant amount of relief within the Muslim community, there is a need for other organizations that provide mental health services to also extend and develop a relationship with the Muslim community to improve the provision of services.

This project also brings forward the possibility for a new model of psychological care, one that involves the community at large rather than relying primarily on the individual to seek help and recover when struggling with mental health issues. As the interviewees explained, immigrants may be trapped in isolation for a number of reasons, contributing to their poor mental health and perhaps making them more prone to depression. Furthermore, in such a state of isolation, they may not have the ability to seek help. As a result, socialization was suggested as a mechanism to assist immigrants to become more comfort-
able in their environments as well as to build a social support network. As this was presented even within the context of a religious responsibility, it was less the responsibility of the individual to seek help and more so the responsibility of the community to help those in need of assistance. The findings suggest not only that mental health care providers should reach out to the Muslim community to better understand the community’s perspective on mental wellbeing, but also to expand the opportunities for the provision of care within a paradigm that extends the understanding of health and wellness from biochemical interactions in the body to processes that can include an entire community.

References


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