A Decade of Muslim Youth: Global Trends in Research

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Keywords: youth, adolescence, young adulthood, mental health

Introduction

Globally, Muslim adolescent and emerging adults are constantly facing scrutiny from their environments. However, very little is known regarding how they perceive themselves and experience the world around them, what their mental health needs are, and how to promote healthy development. The last decade (2005-2015) was characterized by rapid growth and expansion of research on global populations of Muslim adolescents and emerging adults. This paper aims to identify major advances in research, highlight trends, and suggest directions for future research. We begin with the major research trends in global youth research before contextualizing the research on Muslim youth. The paper then explores the major research contributions in identity and development, mental illness, and wellbeing.
General Trends in Adolescent and Emerging Adulthood Research

The last decade has resulted in numerous advances in the field of adolescent and emerging adult psychological research, ranging from research methodology and cross-cultural research, to decoupling of factors impacting youth development, and an increased influence of positive psychology. Advances in research methodology, designs, and innovations in technology have enabled creative approaches to explore the complicated process of youth development, resulting in greater interdisciplinary research (e.g., Syed, Azmitia, & Cooper, 2011), an increase in mixed-methods approach (e.g., Azmitia, Syed, & Radmacher, 2013; Rao et al., 2013), and greater collaboration with “end user”, through approaches such as Community-Based Participatory Research (CBPR) (e.g., Jacquez, Vaughn, & Wagner, 2013), which have resulted in valuable insight. As a result, mental health theories have been extended to global populations to test their applicability. In some cases, current theories have been further confirmed (e.g., Lai et al., 2014; Gupta et al., 2013), whereas in other cases they have revealed cross-cultural differences, resulting in the need to reformulate current theories (e.g., Neese, Pittman, & Hunemorder, 2013; Seiffge-Krenke et al., 2013). This has contributed to the maturation of developmental theories -- such that the individual-context fit, and the bidirectional nature development are now being investigated (e.g., Lerner, 1995; Abo-Zena & Ahmed, 2014; Hafen, Spilker, Chango, Marston, & Allen, 2014). Researchers are studying variations in social contexts (i.e., family, peers, socioeconomic environments, and cultural conditions), conflated factors within these contexts, the influence of changing social processes, and increasingly global cultural context resulting in a more nuanced understanding of adolescent development globally (e.g., Lund & Dearing, 2013; Dhariwal & Connolly, 2013; Rao et al., 2013).

The increasingly multifaceted perspective on development has resulted in researchers utilizing a more nuanced approach when studying risk, protective, and moderating factors in adolescence and emerging adulthood. While the awareness of the dynamic interaction of individual risk and social contexts (e.g., Kretschmer, Vitaro, & Barker, 2014; Boeninger, Masyn, & Conger, 2013), inter-generational transmission of risk (Hipwell et al., 2014), and increased evidence for the clustering of risk behaviors (e.g., Ohene, Ireland, & Blum, 2005) have been undertaken, the identification of modern risks (such as digital settings) are beginning to be explored. For example, although social media and digital contexts have highlighted the negative impact of risk messaging by digital peers, increased cyberbullying, and sexual solicitation, digital contexts have also created buffers that increase communication, build relationships, enhance friendship quality and ability to increase self-esteem, and promote sexual self-exploration (MacLean, Geier, Henry, & Wilson, 2014; Valkenburg & Peter, 2011).
The interest in positive mental health and protective factors highlight the profound impact of positive psychology on adolescent and emerging adulthood research. This has resulted in a paradigm shift from a deficit model to a strength-based model and growth of positive youth development. Researchers are exploring developmental assets among young people (e.g., Tolan, 2014; Hope & Jagers, 2014), as well as ethnic and racial adaptations of positive youth development approaches (e.g., Travis & Leech, 2014). In addition, research on varying forms of intervention, such as activity-based mentoring (Deane & Harré, 2014) and developmental-stage-specific intervention (Vuolo, Mortimer, & Staff, 2014) are charting pathways to more effectively implement research findings with young people. However, there is a great need for more outcome research to determine the effectiveness of prevention/intervention programs for youth from diverse backgrounds (Guerra & Williamson, 2014).

While advances in psychological research have taken place in the last decade, it has had little influence on social policy or programming (Jenson & Fraser, 2015). The impacts of social policy in the lives of young people have been limited, with the exception of a few studies (e.g., Snell et al., 2013; Andersen et al., 2014; Lambert et al., 2014). A developmentally contextualized approach is needed to addresses the multitudes of factors leading to youth risk behavior as well as to promote resiliency in youth through the building of developmental assets, which must be integrated across agencies and systems of care (Jenson & Fraser, 2015). Additionally, in order for research to truly benefit the lives of young people, policymakers must integrate emerging research into current programming, evaluate impact, and adapt to the needs of diverse audience.

Trends in Muslim Adolescent and Emerging Adulthood Research

As the field of research on adolescent and emerging adulthood expanded during the last decade, interest in Muslim populations grew concurrently. Global research on Muslim adolescents and emerging adults has grown exponentially, and in many areas reflect the trends mentioned in the preceding section. This review will limit itself to topics directly related to Muslim youth mental health. In so doing, the review will cover global Muslim youth research specific to identity and development, mental illness, interventions, and wellbeing.

Identity & Development

How a young person identifies themselves (e.g., Muslim or not), the many social identities they carry (i.e., gender, ethnic/racial, socioeconomic status, etc.), and how their environment responds to them impacts their development, mental
health and well-being. The vast majority of research on identity and development among Muslim adolescents and emerging adults has focused on regions where Muslim youth are religious minorities. This may be due to the saliency of their identities within a majority culture. Researchers highlight the need to understand the varying factors impacting identity development, the existence of multiple social identities, as well as the impact on values and behaviors.

Research on identity development of Muslim adolescents and emerging adults highlights the need to consider development from a relational, contextual, global, and fluid perspective, as well as one that considers past spaces and places not currently occupied by young people (Ahmed, Patel, & Hashem, 2015; Fine et al., 2012; Kumar, Seay, & Karabenick, 2015). For example, numerous studies highlighted the impact of sociopolitical contexts as an important factor in strengthening both religious and ethnic identity development across global populations and forms of conflict (e.g., Pinson, 2008; Basit, 2009; Abu-Rayya & Abu-Rayya, 2009; Khandelwal, Dhillon, Akalamkam, & Papneja, 2014). In their study on the religious and ethnic in-group identification of Israeli Arab Muslim youth, Abu-Rayya & Abu-Rayya (2009) noted that more positive outcomes for in-groups identification were observed than identification with the majority group (i.e. Israeli). These finding seem contrary to conclusions Berry’s (1997) theory of acculturation, and encourages mental health providers to acknowledge socio-political and cultural context in models of development. Similarly, the influence of educational context on identity development of Muslim youth populations has highlighted potential institutional roles in racializing Muslim students, experiences of social exclusion, and the impact these experiences have on religious identity (e.g., Keaton, 2005; Mac an Ghaill & Haywood, 2014; Moulin, 2015; Basford, 2008). Basford (2008) described how African-origin Muslims in the U.S. reported perceived academic, religious, and cultural hostility, often feeling hidden and unwelcome in their schools. In this study, parents eventually responded and formed culture-specific charter schools to better accommodate their children’s needs. Additional forms of environmental influence examined the role of media influence (Khan, 2009), socioeconomic factors (Ghaffar-Kucher, 2008), cultural community influence (Kumar, Seay, & Karabenick, 2015), and family context (Britto & Amer, 2007; Dimitrova, Chasiotis, Bender, & van de Vijver, 2014). While preliminary efforts to understand contextual influences impacting development has begun, more contexts need to be investigated in order to provide a thorough understanding of Muslim youth development. In particular, investigations of peer, extended family, religious institutional, and digital contexts are recommended, as these are believed to have immense influence in the lives of young people.

Developmental experiences may impact the prominence of a young person’s religious identity. While some researchers report religious identity to be the most salient aspect of a young Muslim’s identity and helps them navigate
and negotiate their environment (e.g., Ghaffar-Kucher, 2008; Kashyap & Lewis, 2013; Walseth, 2006a), for other young people, the importance of religious identity was mitigated by other social identities and factors in their context (e.g., Maliepaard, Lubbers, & Gijsberts, 2010; Clark, 2007). As a result, the last decade noted an increase in researchers exploring the multiple dimensions of young Muslim’s social identities that are often conflated with religious identity. Some of the social identities include ethnic (e.g., Abu-Rayya & Abu-Rayya, 2009), gender (e.g., Kassissieh, 2005), sports (e.g., Walseth, 2006b), nationalism (e.g., Saroglou & Mathijsen, 2007; Hussain & Bagguley, 2005; Sirin & Fine, 2007), refugee status (Valentine & Sporton, 2009), disability (Hussain, 2005), familial (Dimitrova, Chasiotis, Bender, & van de Vijver, 2014), and language (Jaspal & Coyle, 2010). The intersectionality of these social identities has highlighted the complexity of young person’s identities, internalized values, and subsequent behaviors. In a study on religious identities of young Muslim British women hijab (head covering), often considered a publicly displayed religious marker, was actively embraced and served to further facilitate religious identity development and practice (Hopkins & Greenwood, 2013). However, for young Muslims that report a decrease in religious and ethnic identity, evidence for an increase in acceptance of national values and practices was observed (Verkuyten & Martinovic, 2012). Interestingly, among young Muslims in Belgium, perceived discrimination was observed to translate into increased youth participation in both ethno-religious and mainstream organizations (Fleischmann, Phalet, & Swyngedouw, 2013). The most prominent social identity may also be situational or issue-specific. For example, in separate studies of young British and French Arab women, cultural identities appeared to have a greater impact on maintaining sexual virginity than religious identity, as it served as a symbolic cultural identity marker (Amer, Howarth, & Sen, 2015; Skandrani, Taïeb, & Moro, 2012). The intersection of religious, gender, and communal identity on youth behavior was also noted in data on Muslim youth choices, whether or not they abstain from alcohol and drug use, and the expected response from their community (Bradby & Williams, 2006). The conflation of multiple social identities and its impact on a young person’s subsequent behavior is important to further explore and understand. Various researchers have attempted to conceptualize the interconnectedness of the multiple social identities (e.g., Mishra, 2005; Dimitrova, Chasiotis, Bender, & van de Vijver, 2014; Zaal, Salah, & Fine, 2007), but more research is needed to support their findings as well as better explain when and how a particular identity is most prominent and how it impacts behavioral outcomes.

What is most striking about the research on Muslim youth identity and development is that the vast majority of research has focused on Muslim minority populations. Research is also needed to understand Muslim adolescent and emerging adult development in Muslim-majority nations. While youth in
non-Muslim-majority countries may grapple with their multiple social identities, it is unclear if the saliency of religious identity would be as prominent in Muslim-majority nations.

Mental illness

Accurate information on mental illness within global populations of Muslim adolescents and emerging adults is currently difficult to obtain due to a multitude of factors, including mental health illiteracy, stigma, accessibility of facilities, and a lack of funding and documentation. However, the last decade has helped build the foundation for what is needed to reduce the gap in our knowledge. Preliminary research on help-seeking behaviors, mental illness, risk factors, and intervention with young Muslims have been undertaken in both Muslim-majority and -minority countries and is presented below.

Help seeking

Research continues to show low levels of mental health literacy among Muslim adolescents and emerging adults, which impacts their ability to recognize mental health problems, and often results in misattribution of symptoms (Essaú, Olaya, Pasha, O’Callaghan, & Bray, 2012; Raja, 2004). In communities experiencing historical, constant intimidation and violence, such as in the case of Palestinian Muslims, young people reported they did not seek help because they minimized the trauma experienced, did not believe obtaining help would change their situation, and desire to maintain their independence (Guterman, Haj-Yahia, Vorhies, Ismayilova, & Leshem, 2010). One compounding factor is the remote dispersal of mental health services across large regions of many Muslim majority countries, increasing access difficulties. For adolescents in countries with accessible care, such as in the U.K., underutilization was attributed to not wanting to share their problems with “strangers” (Randhawa & Stein, 2007). These factors, combined with mental health stigma, often result in young people’s unwillingness to seek professional treatment (Raja, 2004). Instead, young Muslims relied on primarily friends, family, and spiritual healers to help cope with mental health issues (e.g., Al-Krenawi & Graham, 2011; Haroun et al., 2011).

However, research in the U.S. has highlighted the potential role of religion, parental support, and physicians in young patient’s acceptance of mental health diagnosis and willingness to obtain treatment (Haroun et al., 2011; Herzig, Roysircar, Kosyluk, & Corrigan, 2013, Herzig, 2011). These findings suggest that while underutilization of services continues, public health efforts to increase mental health literacy, more government funding to expand accessibility in Muslim-majority countries, and creative approaches to reduce mental health
stigma are all needed. Potential methods to influence young Muslims’ mental health beliefs and attitudes may include the use of social media (Din, Ahmed, & Killawi, 2016) as well as collaboration with individuals (e.g., religious leaders, community organizers) and institutions valued by young people.

**Disorders**

Research on the prevalence of DSM-5/ICD-10 categorization of mental illnesses on adolescent and emerging adult Muslim populations is limited. Despite preliminary studies on the prevalence of specific disorder, it is believed that mental illness is grossly underreported and therefore is not presented in this review. Instead issues and trends on specific mental illnesses that have received research attention will be highlighted in order to provide direction in the coming years. Specifically, anxiety-related disorders, depression symptomatology, and eating disorders are addressed below.

While anxiety is globally documented, surprisingly few studies have explored anxiety disorders among Muslim adolescents and young adults (e.g., Essau, Olaya, Pasha, O’Callaghan, & Bray, 2012; Ahmadi et al., 2014). In a study on anxiety levels in populations of Muslim-majority countries, significant gender differences were noted in some countries (i.e., Egypt, Iraq, Morocco, Kuwait, Oman, Qatar, Lebanon, Pakistan, Algeria Yemen, and Syria), while in other countries (i.e., Saudi Arabia, Jordan, Sudan, the United Arab Emirates, and Palestine), no differences were observed (Alansari, 2006). These findings highlight the potential role of sociocultural contextual differences, warranting further investigation. In a study on Saudi patient perceptions of OCD symptom presentation, when symptomology was expressed within ritualistic aspects of worship (prayers), they were considered more upsetting than symptomology present in other areas of daily functioning (Al-Solaim & Loewenthal, 2011). This study emphasizes the need to consider the contextual meaning and impact of symptom presentation in the lives of young people. In addition, risk factors associated with anxiety disorders among adolescents need to be studied in order for preventative efforts to be undertaken (Ahmadi et al., 2014; Shams, Foroughi, Esmaili, Amini, & Ebrahimkhani, 2011). Studies on anxiety have examined comorbid conditions, such as depression and body dysmorphic disorder (Barahmand & Shahbazi, 2015; Shams, Foroughi, Esmaili, Amini, & Ebrahimkhani, 2011), which will be important for assessment and intervention purposes. In addition, examples of how institutional policy can contribute to anxiety symptoms were investigated in a Turkish study, which found the inability to wear hijab due to the headscarf ban in Turkish universities, resulted in partial-hijab-wearing young women experiencing symptoms of guilt, fear, and anxiety (Seggie & Austin, 2012). Potential evidence for digital contribution to symptoms of anxiety was found in an Iranian study (Ahmadi et al., 2014). At
present, there is insufficient research on anxiety symptoms, etiology, and risk and protective factors, while intervention and prevention are needed.

Ethnic cleansing, political and civil wars, and natural disasters during the last decade have resulted in large concentrations of Muslim youth experiencing considerable loss and trauma. When studying tsunami child survivors, researchers noted that Muslim children often incorporated religious attributions in order to cope with traumatic events, resulting in the need to re-conceptualize current explanatory models of trauma (Dawson et al., 2014). The type of trauma, whether natural disaster or war-related, has been shown to impact the course and presentation of PTSD. In a study on child survivors of the Indonesian tsunami, the level of PTSD symptoms did not differ between those who had single exposure to trauma compared to those who had multiple experiences of trauma (Agustini, Asniar, & Matsuo, 2011). In this study, factors that increased the severity level of PTSD symptoms included being female, somatic response to trauma, loss of parents, and low support levels (Agustini, Asniar, & Matsuo, 2011). However, for war-related trauma, researchers found that direct exposure, brutality of trauma, and number of traumas experienced were all related to the severity of PTSD, depression, and social dysfunction (e.g., Ellis, MacDonald, Lincoln, & Cabral, 2008; Fazel, Reed, Panter-Brick, & Stein, 2012; Hasanović, Sinanović, & Pavlović, 2011). For example, Hasanović, Sinanović, and Pavlović (2011) found that young Srebrenica survivors had the greatest severity and prevalence of PTSD among Bosnian refugee adolescents studied, and attributed the intensity of horror experienced as one possible reason for the higher levels of PTSD compared to survivors from other regions.

The extent of resettlement stress for refugees from war-torn areas served as a greater predictor of psychological problems than the initial traumatic experiences itself (Fazel, Reed, Panter-Brick, & Stein, 2012). These stressors include: acculturative stress, perceived discrimination, depressed living conditions, school-related anxiety, family discord, and daily stressors (Ellis, MacDonald, Lincoln, & Cabral, 2008; Fazel, Reed, Panter-Brick, & Stein, 2012; Fernando, Miller, & Berger, 2010; Jones & Kafetsios, 2005). Among U.S. Iraqi refugee adolescents that have experienced multiple types of trauma, researchers found that those experiencing discrimination and backlash had the poorest mental health outcomes, after controlling for life trauma (Kira, Lewandowski, Chiodo, & Ibrahim, 2014). While some risk factors for PTSD have been identified, more research is needed. Limited research on protective factors of displaced individuals or those living in oppressed communities (e.g., Palestinians) found that young people with strong ethnic identification, abilities to obtain social support, and those who relied upon religious coping had better mental health outcomes, with some gender differences noted (Ellis, MacDonald, Lincoln, & Cabral, 2008; Kira, Alawneh, Aboumediene, Lewandowski, & Laddis, 2014). As researchers continue to explore the impact of trauma on young refugees, it is
important to understand the long-term impact of trauma, to engage in greater research on protective factors buffering the impact of trauma, and to highlight environmental factors and government policies that may better support the adaptations of young refugees. In addition, research addressing other forms of trauma and stress is desperately needed. In Western countries where Muslim adolescents and young adults are increasingly facing discrimination and hate crimes, how do young people internalize these experiences? Are these experiences more pronounced for some ethnic/racial groups than others? What are the long-term mental health impact of sustained, diffuse, societal intimidation and discrimination? What are protective factors that can serve to buffer young people in these environments? These and other questions need to be addressed in future trauma studies.

The study of depression within Muslim adolescent and emerging populations varies across prevalence reports (e.g., Sajjadi et al., 2013; Alansari, 2006; Rahman et al., 2009). Similar to anxiety disorders, gender differences have been noted. In some Muslim-majority countries (i.e., Iraq, Syria, Egypt, Pakistan, Algeria, Oman, Qatar, Morocco, and Kuwait), female participants reported higher levels of depressive symptoms, In Saudi Arabia, however, young male participants reported greater levels of depression (Alansari, 2006). In other Arab countries (i.e., Lebanon, Tunisia, Palestine, United Arab Emirates, Yemen, Jordan, and Sudan), there was no significant gender difference in reported depression levels, highlighting the potential role of social-cultural context in contributing to presentation (Alansari, 2006). Research reflects increased risk factors associated with depression include poor academic performance (Sajjadi et al., 2013); ineffective parenting style, poor relationships between parents and parent-child, lower parent education (Sajjadi et al., 2013), family acculturation context fit (Asvat & Malcarne, 2008); socioeconomic status (Sajjadi et al., 2013); majority/minority status (Iqbal, Ahmad, & Ayub, 2013); extent of urbanization (Rahman et al., 2009); immigration status (van Geel & Vedder, 2010); and perceived discrimination (Tummal-Narra & Claudius, 2013).

Suicidal behaviors -- including ideation, attempts, and completions -- are often associated with severe depression. While studies investigating prevalence have been undertaken, researchers warn that gross underreporting is likely, given prohibition of and stigma associated with suicide in Islam (Gal et al., 2012). The prevalence of suicide attempts have been investigated in countries such as Pakistan, Iran, and Malaysia (Khokher & Khan, 2005; Groohi, Rossignol, Barrero, & Alaghehbandan, 2006; Chen, Lee, Wong, & Kaur, 2005). While some researchers noted gender differences (Groohi, Rossignol, Barrero, & Alaghehbandan, 2006; Chen, Lee, Wong, & Kaur, 2005; Syed & Khan, 2008), others did not (Khokher & Khan, 2005). The level of risk facing Muslim adolescent suicidal attempts also appears to differ. For example, in a study conducted in Malaysia, Muslim Malay adolescents reported the lowest risk
for suicidal attempts compared to Malaysians of other religious backgrounds (Chen, Lee, Wong, & Kaur, 2005); in other countries, such as Netherlands, Turkish youth have higher risk for suicide attempts than non-Turkish youth (Burger, van Hemert, Schudel, & Middelkoop, 2009). It is unclear if the differences noted are related to differences in majority/minority status, ethnic affiliation, socioeconomic conditions, level of stress or discrimination, or some other unknown factors. Studies have suggested that suicidal risk factors may include being female, single, in the presence of family conflict, lower socioeconomic status, mental health issues, marriage problems, and greater reports of stress (Khokher & Khan, 2005; Groohi, Rossignol, Barrero, & Alaghehbandan, 2006; Rezaeian, 2010; Ineichen, 2008). While risks have been identified, cross-cultural comparisons between Muslim adolescents/young adults across countries as well between Muslim and non-Muslim peers are needed to better understand suicide in Muslim populations. How Muslim adolescents and young adults choose to attempt suicide may also vary cross-culturally. Preliminary studies noted young people attempting suicide in Pakistan predominantly overdosed using benzodiazepine (Syed & Khan, 2008); in Iran, young people attempting suicide often engaged in self-immolation (Groohi, Rossignol, Barrero, & Alaghehbandan, 2006); whereas, a U. K. study noted that self-immolation within its states was on the decline during the last decade (Ineichen, 2008). In addition to further studies on suicide, risk and protective factors, and the effectiveness of current prevention programs, qualitative studies on how individuals and their families cope with suicidal attempts and completions, given religious prohibition, are recommended.

Finally, eating disorders are increasing within Muslim populations. Researchers are reporting high prevalence of problematic eating attitudes among Muslim populations (e.g., Latzer, Azaiza, & Tzischinsky, 2009; Thomas, Khan, & Abdulrahman, 2010; Mousa, Al-Domi, Mashal, & Jibril, 2010; Abraham & Birmingham, 2008). Interestingly, significant gender differences were not noted in Arab countries (Schulte & Thomas, 2013; Latzer, Azaiza, & Tzischinsky, 2009) but noted in Pakistan (Memon et al., 2012). Given the limited number of studies, it is difficult to draw any conclusive statements and therefore warrants replication. Triggers and risks associated with eating disorders are currently being explored. One study in Turkey reported an increased report of eating disorders coinciding with the Ramadan, the month of fasting for Muslims (Akgül, Derman, & Kanbur, 2014). This has raised questions whether drastic changes in meal habits may contribute to triggering eating disorder among adolescents that are predisposed or current unreported cases (Akgül, Derman, & Kanbur, 2014); more research is needed before a conclusion can be made. Cultural values specific to socioeconomic class may also contribute to unhealthy eating attitudes. In a within-group study comparing eating attitudes of Pakistani females attending English (middle socioeconomic status) and Urdu (lower socio-
cioeconomic status) medium schools, researchers found that English-medium students expressed more negative eating attitudes (Mahmud & Crittenden, 2007). While research on eating disorders is ongoing, much more is needed to parse out the varying factors that may contribute to the increasing prevalence. Some questions to consider include family and social risk factors, as well as the digital impact of body images given increasing social media use by Muslim adolescents and emerging adults.

A review of the global research on mental illness highlights the foundations that have been built during the last decade. However, analysis of current research draws attention to the many gaps that exist within our knowledge. Accurate prevalence rates among Muslim adolescents and emerging adult populations of most mental illnesses are unknown. Similarly, differences in prevalence rates by ethnicities need to be further explored. For example, why are some researchers noting higher rates of Pervasive Developmental Disorders among Somali children in Sweden (Barnevik-Olsson, Gillberg, & Fernell, 2008; Barnevik-Olsson, Gillberg, & Fernell, 2010)? Are there other disorders that have a higher prevalence by ethnicity, minority status, or geographical location? In addition, cross-cultural comparisons between young Muslims in Muslim-majority versus -minority countries are needed in order to better understand socio-cultural influences on mental illness.

Interventions

Among Muslim adolescents and emerging adults, minimal research has been conducted on mental health interventions, clinical, psycho-education or otherwise. Publications have primarily covered cultural consideration for specific ethnic groups (e.g., Yilmaz, Dalkilic, Al-Mateen, Sood, & Pumariega, 2013; Whittaker, Hardy, Lewis, & Buchan, 2005), presented individual case studies (e.g., Bragazzi, & del Puente, 2012; Kennedy, Godlas, Gale, & Parker, 2010), or highlighted considerations based on clinical experience (e.g., Ahmed, 2012). Recommendations for working with Muslim youth in individual psychotherapy have included the suggestion for clinicians to engage in critical consciousness, use of an ecological approach in assessment and treatment, and integrating religious consultants when needed (Ahmed, 2012; Kennedy, Godlas, Gale, & Parker, 2010; Bragazzi & del Puente, 2012; Suárez, Newman, & Reed, 2008). While little is known globally about Muslim youth psychotherapeutic preferences, studies with U.S. emerging adults reveal a preference for individual therapy compared to psychotherapeutic options (Raja, 2004). In a separate study on U.S. emerging adults, young Muslims favored therapists with cultural competency training and knowledge on emerging adulthood needs (Herzig, 2011). However, it is unknown if these findings are generalizable to emerging adults in Muslim-majority countries, which have collectivist social values. There have
been no known large-scale clinical trials to identify the most effective individual psychotherapy approach for the treatment of mental disorders within Muslim adolescent and emerging adult populations. Smaller studies have evaluated the effectiveness of cognitive behavioral and psychodynamic intervention using individual psychotherapy for young Muslims suffering from depression; both interventions reported treatment gains in post-treatment follow up (e.g., Hamdan-Mansour, Puskar, & Bandak, 2009; Heidari, Lewis, Allahyari, Azadfallah, & Bertino, 2013).

Group-based interventions with Muslim youth populations have also received attention from researchers. The vast majority of research on group-based intervention efforts have been in school settings. The primary target of school interventions has been to reduce symptoms of trauma. Some studies evaluated the effectiveness of group counseling interventions that address grief and forgiveness in traumatized populations and noted treatment gains (e.g., Cox et al., 2007; Shechtman, Wade, & Khoury, 2009). Other studies have investigated the effectiveness of both content and systems interventions. For example, a study aimed at supporting Bosnian adolescents’ post-war recovery integrated a multi-tiered intervention into schools (Layne et al., 2008). In the study, surviving children were provided psycho-education and coping skills (tier 1); those who previously experienced severe trauma and loss were provided specialized trauma- and grief-focused intervention (tier 2); and young people with acute symptoms were referred to community-based mental health services (tier 3). This multi-tiered, school-based intervention was found to be significant in reducing grief reactions and may serve as a model for future interventions with child refugees from war-torn areas (Layne et al., 2008). Preliminary evidence for the effectiveness of group interventions have also been observed for health education and skills-based intervention in both Muslim-majority and -minority countries. A study in Iran implemented a skill-based intervention program that reduced substance use among Iranian high school students, with treatment gains maintained one year after intervention (Allahverdipour, Bazargan, Farhadinasab, Hidarnia, & Bashirian, 2009). Other studies have explored the impact of health- and religious-education-based interventions to reduce smoking among Indonesian Muslim youth, and found positive effect for use of both (Tahlil, Woodman, Coveney, & Ward, 2013). Similarly, evidence for the positive impact of group intervention on developing resilience, positive self-concept, and strengthening religious identity was observed in Muslim Malay female orphans (Kamsani, 2014).

While family and humanistic therapy are purported to be the most effective forms of therapy with Muslim populations, no empirical research has been conducted to assess their effectiveness. Similarly, culturally based therapeutic interventions have also been described without empirical evidence (Dwairy, 2009). Future research on the effectiveness of interventions with Muslim ado-
lescents and emerging adults is imperative. Researchers must focus not only on providing empirical evidence for the type of intervention, but also to identify the therapeutic factors and practices that enhance treatment for Muslim adolescents and emerging adults.

Wellbeing

Similar to the overall field of psychology, positive mental health and wellbeing has sparked interest among researchers studying global Muslim youth populations. The positive impact of religiosity has been extensively studied by researchers primarily from the Middle East. These studies have noted that increased religiosity served as a buffer against depression and anxiety and had a positive relationship to happiness and wellbeing (e.g., Yapici & Bilican, 2014; Abdel-Khalek, 2007; Abdel-Khalek & Naceur, 2007; Vasegh & Mohammadi, 2007). Similarly, a study in the U.K. found that Muslims minorities had the lowest levels of psychological distress when compared to other faith groups (Dabbagh, Johnson, King, & Blizard, 2012). Lower levels of distress were attributed in part to being part of a religious minority community that had strong sense of social cohesion (Dabbagh, Johnson, King, & Blizard, 2012). It would be important to see if these findings would be replicated in other countries with both Muslim- and non-Muslim- majority youth populations. It is possible that other factors may contribute to the findings and should also be investigated. For example, religious and ethnic identification in minority group settings was shown to support a young person's self-concept and positively impact their sense of wellbeing (Abu-Rayya & Abu-Rayya, 2009). There may be other social identities or factors that could contribute to the subjective wellbeing of Muslim adolescents and emerging adults and should be considered.

Positive psychology research has been advanced in numerous countries with large Muslim populations. In Iran, research has primarily focused on the validation of positive psychology research measures and concepts related to resilience and mindfulness (e.g., Jowkar, Friborg, & Hjemdal, 2010; Ghorbani, Watson, & Weathington, 2009; Ghorbani & Watson, 2009). Researchers have explored correlates of happiness (Abdel-Khalek & Lester, 2010), as well as differentiating between different types of gratitude (dispositional versus religious) and its predictive impact of mental health and subjective wellbeing (Aghababaei & Tabik, 2013). Research on factors related to positive youth development has also begun; for example, the relationship between religiosity and the development of character strengths was explored with U.S. Muslim college students (Ahmed, 2009). In the study, religious minority status and socio-political cultural context were identified as potential factors resulting in higher levels of religiosity among U.S. Muslim college students when compared to their non-Muslim peers (Ahmed, 2009). In addition, preliminary research among
Muslim minority youth identified that strong family structure, positive parent-child relationship and home environment, positive school environment, and academic success promoted youth development (e.g., Aroian, Templin, Hough, Ramaswamy, & Katz, 2011; Azam & Shaikh, 2011; Dabbagh, Johnson, King, & Blizard, 2012). In Muslim-majority countries, to the knowledge of the authors, only two known studies on youth promotion exist. The first, conducted in Malaysia, noted that among Muslim Malay youth, religiosity was the most important variable to promote pro-social behaviors; positive parenting practices served as the most significant protective factor against risk behaviors; and community support was the most vital element to help young Muslims thrive (Krauss et al., 2012). In a study on Pakistani adolescent youth development, personal growth initiative was noted to have a positive relationship with well-being and a negative relationship with levels of distress (Ayub & Iqbal, 2012).

While research on positive psychology and youth development exists, much more is needed. For example, while religiosity has been found to be a protective factor, the mediating factors and pathways of function are unclear. How Muslim adolescents and emerging adults compare to youth of other faith groups expressing similar levels of religiosity should also be investigated. Similarly, while Muslim youth development research has begun, these findings must be incorporated into programming, with evaluations of their effectiveness in Muslim youth populations across socio-contextual environments.

**Recommendations for the Next 10 Years**

The global increase in research on Muslim youth is a welcome development; however, the field is still in its infancy stage and major gaps in the research continue to exist. Minimal research has been conducted on important topics that impact Muslim adolescent and emerging adult development and mental health. For example, peer relationships are known to influence young people’s developmental trajectory yet minimal research on peer relationships appears to exist. Similarly, Muslim youth are developing within a global context, actively engaging and connecting through social media, and in some cases sharing global popular culture through music, art, and social justice causes. However, minimal research has been undertaken to investigate the impact these influences have had on global Muslim youth populations. While Muslim adolescents and emerging adults may share similar values and beliefs, they also have additional social identities which may result in unique issues specific to their socio-political/cultural histories, as is the case of African American Muslim youth.

Increased research on reducing mental health stigma, effective programming for mental health literacy, and greater funding to establish baseline mea-
sures for the global prevalence of mental illness by country and cultural groups is needed. Research to identify cultural manifestations of mental illness, as well as treatment interventions that are best suited by populations and disorders will help clarify mental illness presentations. In addition, sustained attention is needed to examine the long-term impact of global unrest on the mental health of displaced Muslim youth.

Additional gaps in research include limited information about Muslim youth in African countries as well as Muslim-minority populations in South and Central America. It is possible that research may exist on many of the topics highlighted in this review, however language barriers between researchers may interfere with access. Thus, efforts are needed to ensure greater collaboration and exchange of knowledge across languages. In addition, country-specific longitudinal studies are needed to begin exploring developmental changes and trends over multiple generations. Identifying within-country differences as well as cross-cultural studies of Muslim youth are also needed to understand the nature of varying factors that influence Muslim adolescent and emerging adulthood outcomes. In addition, much of the available research has not been incorporated into social policy and programming and cannot be evaluated for its greater social impact.

Despite the need for additional research, the immense contribution and expansion of knowledge on the global mental health of Muslim adolescents and emerging adults should not go unnoticed. The foundations for research have been established and expectations for the next decade run high.

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