The Imam and the Mental Health of Muslims: Learning from Research with Other Clergy

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Introduction

Clergy occupy an important position when it comes to addressing the mental health of their congregants, according to research spanning several decades in communities across the United States (Weaver, 1998). At this time, limited research supports that this statement also applies to imams and Muslims. What still needs to be done in order for us to draw solid conclusions about how imams impact the mental health of Muslims in their communities? This report summarizes major trends and findings from the literature on clergy and imams and suggests a framework for future studies to address mosque-based mental health counseling needs of Muslims.

General Trends in the Literature on Clergy

The literature involving clergy has included a) assessing whether or not people in the general population seek help from clergy for mental health-related problems, b) recognizing clergy’s (including pastoral counselor and chaplain) men-
Clergy pastoral counseling practices (for people with mental illnesses) have been well described in the literature. In a 1986 study of 214 south-central Connecticut clergy, Mollica and colleagues found that, in addition to pastoral counseling (58%), black clergy (52%), traditional clergy (46%), and evangelical clergy (31%), reported spending most or some of their time counseling people with mental illnesses (Mollica, Streets, Boscarino, & Redlich, 1986). A review of the literature from the early 1990s indicated that clergy spent about 15% of their 40- to 60-hour work week on pastoral counseling; considering the number of rabbis, priests, and pastors in the U.S., that is more counseling hours than provided by all of the members of the American Psychological Association that there were in the year of publication (Weaver et al., 1997). In a survey of 99 African American clergy in Connecticut, Young and colleagues concluded that urban ministers were essentially functioning as pastoral counselors, averaging over six hours of weekly counseling (Young, Griffith, & Williams, 2003). In a survey of 179 Catholic, Jewish, and Protestant clergy from the catchment areas of four hospitals in New York and Connecticut, Moran and colleagues found that clergy overall spent about 6 hours per week in pastoral counseling (Moran...
et al., 2005). In a study of 98 Christian clergy members in Hawaii (which included a ten-minute survey with two case vignettes), most reported spending between one and five hours per week in counseling (including treating people with mental illnesses; Farrell & Goebert, 2008). In a study of 103 Asian American Christian clergy responses to an anonymous mail-in questionnaire, 48% reported they often or almost always providing individual counseling themselves (Yamada, Lee, & Kim, 2012). Some studies have included the assessment of clergy in parallel with assessments of mental health professionals (Domino, 1990; Milstein et al., 2000). Importantly, many of the studies with clergy also assessed attitudes toward mental illnesses, responses to clinical vignettes, and/or actual referrals to mental health professionals.

Addressing the collaborative relationships between clergy and mental health professionals in a review of the medical and psychological literature published between 1980 and 1999, Weaver and colleagues described seven themes that emerged from 44 articles: referral practices, benefits of collaboration and referral, identifying clergy as frontline workers to the mental health care system, barriers to collaboration, mutual provider education, similarities and differences in professional values, and the role of clergy in the prevention of illness (Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). They highlighted ethnic minorities, rural Americans and older adults as having natural linkages between member of the clergy and mental health specialists. Upon inclusion of journals covering religion and health, they concluded there remains a need for greater collaboration and mutual education. Milstein and colleagues have developed a model for caregiver collaboration with clergy based upon the shared goals to reduce burden of care and to be inclusive of religious values. Using prevention science categories, caregivers and clergy are guided on when and how to intervene with congregants (Milstein, Manierre, Susman, & Bruce, 2008).

The community-based participatory research paradigm trending in the past decade (Hohmann & Shear, 2002; Wells et al., 2004; Wallerstein & Duran, 2010) coalesces research, clinical, behavioral science, and administrative principles and tools; the paradigm’s goal is to bring evidence-based practices directly to real world arenas and evaluate their effectiveness while they are being provided. This strategy reduces the delay between research and implementation of practical, clinically relevant research findings, and is particularly important for underserved areas. These programs allow for adaptations in care to be relevant to the specific community, and provides an environment for practice-based quality improvement.

Implementation research has been promoted for mental health programs (Proctor et al., 2009), but behavioral health-related programs have existed in faith-based communities outside of the research paradigm. In a review of the literature on church-based programs in African American communities that
include mental health counseling in addition to social services, Taylor and colleagues were able to provide several suggestions for social work services to interface with black churches and the need for more formalized research assessments. The potential for community-based health promotions programs in black churches is substantial and needs further research (Campbell et al., 2007). In general, faith-based health programs “can produce positive effects” but more effectiveness studies are needed (DeHaven et al., 2004).

The Muslim Mental Health Literature

In contrast to the epidemiologic studies of thousands of other Americans, there has been no systematic assessment of Muslims’ attitudes toward or reports of seeking help from imams for mental health-related issues. The Mosque in America Study (Bagby, Pearl, & Froehle, 2001) which involved interviews of mosque leaders, found that mosque-goers seek help for social and mental health-related needs. Still, little can be said about whether or not Muslims find their needs adequately met, and how those needs might vary by the demographics of the individuals wanting assistance. For example, what are the attitudes and experiences of Muslim youth and women toward seeking help from imams for mental illnesses and/or social problems?

In contrast to the dozens of studies of clergy across the United States, only one study has been conducted that specifically surveyed imams nationwide on their counseling behaviors, ability to recognize serious mental illness, attitudes toward causes and solutions to mental health-related problems, willingness to refer to mental health professionals, and actual reported consultative or referral practices (Ali, Milstein, & Marzuk, 2005). This study established that imams do provide counseling for mental health-related needs of their congregants but did not have the adequate training, staffing, or resources at their mosque. The authors concluded that imams on average could recognize someone with a mental illness and showed a willingness to refer out but preferred referral while continuing to provide counsel themselves (Ali & Milstein, 2012). Their low levels of actual referrals may suggest the imams did not have an adequate referral base.

Based upon interviews of 22 imams and 102 congregants in the NYC area, Abu-Ras and colleagues found that congregants viewed the imam as someone they turn to for religious guidance as well as counseling (Abu-Ras, Gheith, & Cournos, 2008). In 2009, Padela and colleagues interviewed 12 community leaders (including two imams) in southeastern Michigan and found that in addition to delivering sermons and performing religious rituals, imams were expected to be involved in cultural sensitivity training and to advocate for Muslim patients in hospitals as well as to be involved in healthcare decision-making for
their congregants (Padela et al., 2011). In a pioneering mixed-methods survey of 56 pastoral-care directors and 33 Muslim and non-Muslim chaplains in New York City, Abu-Ras found that despite the overwhelming need for their services (which were expected to be similar to other chaplains), there were only two board-certified chaplains in the entire New York City public hospital system (Abu-Ras, 2010); the survey also found that the needs for Muslims may not readily be met using the interfaith chaplaincy model (Abu-Ras & Laird, 2011).

This literature survey could find no studies exploring the potential role of imams in reducing stigma against mental illness in their communities. For that matter, this survey could locate little data on imams’ professional values and their areas of concordance with mental health professionals’ values. There is growing interest in the development of “Islamic Counseling” or “Islamic Psychology” as a distinct field. Although various communities are providing educational programs for Muslims or training programs for their community leaders and imams, this survey located only one program utilizes a model that has some evidence base. Mental Health First Aid (which provides basic knowledge and skills for anyone to become comfortable recognizing, supporting, and referring people with mental health-related problems) is offered to imams, community leaders, and members of the Muslim community by the Muslim Wellness Foundation. However, none of the programs are direct-care oriented nor have they been evaluated and described in the academic literature.

Recommendations for the Next Ten Years

Research on the imam’s role in addressing the mental health of Muslims lags far behind that of other clergy in the U.S, and the available studies highlight a concerning issue: Imams are likely sought by Muslims to provide mental health care, including for people with mental illnesses and psychosocial problems, but they do not have the support or training to manage the growing mental health counseling needs of their communities. Therefore, I suggest that in the next decade, public health officials, administrators, clinicians, academic researchers, and other stakeholders keep in mind several considerations, before engaging in any future research projects that involve imams and mental health: a) deemphasize studying imams in isolation, b) clarify Muslims’ attitudes toward “non”Islamic versus “un”Islamic interventions, c) evaluate existing programs, and d) create services-based research.

When research with Muslims or imams is conducted not in isolation but in context of other general studies, the validation of the findings is enhanced and placed in comparison to other communities so that variations in needs can be identified. For example, imams’ roles in the mosque are different than other clergy, so they may not be able to fulfill the direct care, referral, and collabora-
tion roles they are expected to perform. Furthermore, the imam is only one of a number of people who may be providing mental health-related services. Muslims of a particular community may be accustomed to going to other religious scholars for advice, spiritual or folk healers outside of the mosque; in hospitals or institutions, they may need to access Islamic chaplains. Further studies should involve several providers within the same community or specific providers across faith communities.

One of the reasons why Muslims go to imams and other Muslim leaders is that they do not want to engage in anything that violates core Islamic principles. This has implications for an imam's willingness to refer to a non-Muslim provider and on how the imam may be an important ally for non-Muslim providers. It also has implications on which services Muslims are willing to accept. Muslims may not know the difference between un-Islamic practices and non-Islamic practices. Therefore, they are faced with accepting empirically based practices that are packaged as being within an Islamic framework or new interventions that are based primarily on Islamic principles and borrow from evidence-based medicine.

Despite the lack of research on clarifying roles of imams and understanding the communities’ needs, nonprofit organizations have begun training imams to recognize and address people with mental health concerns. The efficacy and utility of these training programs need to be assessed so that they may be expanded if appropriate. Additional innovative programs are needed that respect Islamic principles while integrating evidence-based medicine.

The reason for suggesting interventions-based research at this stage is two-fold. Primarily, the fear-based climate in the U.S. since 9/11 toward Muslims has negatively affected the likelihood for engagement in broad-based surveys of Muslims and Muslim leaders. Secondly, there is an urgent need to support imams with interventions that can address the stress and mental health problems of their community members. Although interventions are proposed and/or running in mosques, none of them have a strong infrastructure for empirical validation, clinical service or replication across communities.

Therefore, while incorporating the previously described principles, the academic research and clinical communities need to engage into a mutually beneficial relationship with imams and other religious leaders that may help their communities address mental health, substance abuse, and psychosocial problems based upon the recurring themes found in the research: the needs for more mental health education, and a direct connection to providers conducting evidence-based care appropriate to the individual's needs. This intervention-based translational research ought to help models develop empiric validation and become replicable across communities and scalable within communities. In addition to qualitative data, initial priority metrics for these programs ought
to include numbers served, internal and external referrals made, educational impact assessments, and consumer and provider satisfaction.

In conclusion, although compared with the literature on clergy in general, there is limited but suggestive data on imams’ roles in addressing the mental health of their community members, and there is an urgent need to propel the academic, clinical, and religious communities to translate publications into practice and back.

References


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