Mental Health Help-Seeking Pathways in the Muslim American Community: An Exploratory Study

Abstract

Muslim Americans underutilize mental health services despite the prevalence of common mental health disorders within the community. This study seeks to fill in the gaps in previous research that has primary focused on barriers to help-seeking, by examining the pathways taken by Muslim Americans who have utilized any form of mental health services at least once. Three hundred and twenty-five adults identifying as Muslim American were recruited through a national Qualtrics survey panel to complete an anonymous questionnaire on usage of mental health services including provider preference, type of service, mode of service and length of service usage. Findings suggest most participants (67%) sought services on their own, turning primarily to primary care physicians. Reasons for seeking services and the type of services used varied with most using face to face services (75%) and some form of talking therapy (52%). Preference for service providers who are of the same gender and religious or cultural background supports the need to increase Muslim providers and religious and spiritual competency training. A help-seeking pathway model based upon the findings is presented. Understanding patterns of help-seeking behaviors of those who have successfully accessed services is vital to increase future service utilization for Muslim Americans.

Keywords: Muslim American, Stigma, Service Utilization, Discrimination, Provider Preference, Problem Recognition, Religious Competency

Introduction

The Muslim American community has seen a rise in poor mental health outcomes, often tied to experiences of discrimination and Islamophobia (Hailes & Tummala-Narra, 2024; Abuelezam &

El-Sayed, 2021; Abuelezem et al., 2022; Lowe, Tineo & Young; 2019; Hodge, Zidan & Husain, 2016). For example, studies show Muslim Americans have similar prevalence rates for mood and anxiety disorders as the rest of the U.S. population (Ahmad et al., 2023). In addition to anxiety and mood disorders, Muslim American are frequently diagnosed with adjustment disorders (Basit & Hamid, 2010) which may reflect the struggle of many in the community with acculturation and the impact of Islamophobia. Despite the growing need for mental health services, Muslim Americans continue to underutilize such services, especially immigrant and refugee Muslims (Almutairi, Seven, Poudel, & VanKim, 2002) for a variety of reasons including stigma, religious and cultural beliefs, and lack of understanding of mental health services (Mechammil, Boghosian & Cruz, 2019; Sabado, Tram, Khan & Lopez, 2023; Elahi, Elsayed, Ali & Awaad, 2023; Zia & Mackenzie, 2024; Alhomaizi et al., 2018; Ali, Mahmood, McBryde-Redzovic, Humam & Awaad, 2022). Additionally, negative attitudes or beliefs about mental health services including counseling and Western models of psychiatric treatment (Bagasra, 2023) differences in beliefs about the causation of mental illness (Mudryk & Johnson, 2023; Bagasra & Mackinem, 2014), and turning to alternative sources for support (Sabado, Tram, Khan, & Lopez, 2022). Other factors impacting help-seeking include Islamophobia and bias toward Muslim clients (Mclaughlin et al., 2022; Moscovitz, Bedi & Outadi,2023; Winklejohn, Drinane & Akef, 2023) and the lack of availability of providers who meet client preferences (Shafi, 1998). These barriers in the path to help-seeking have been supported by the concept map developed by Tanhan & Young (2021).

Efforts to understand the rates of disorders and service utilization are hampered by low participation of the Muslim American community in research (Amer & Bagasra, 2013), and the majority of studies focusing on smaller subsets of the Muslim population broken down into specific ethnic groups or by gender (Abuelezam & El-Sayed, 2021; Pampati et al., 2018). In order to address the current gaps in knowledge this study explores the help-seeking pathways

that led Muslim Americans to seek out and utilize mental health services in order to understand what circumstances may lead to successful help-seeking behavior and develop a conceptual model of help-seeking within this community.

Theoretical Framework of Help-Seeking Pathways

The most recognized framework of help-seeking among ethnic minorities was proposed by Cauce and colleagues (2002) in which there are three distinct stages to the help-seeking process: problem recognition, the decision to seek help, and service selection. They argue that to understand help-seeking one must consider both culture and context. The first stage, problem recognition, may come internally from the individual's awareness that they are having issues that are interfering with their ability to function or are causing distress. Problem recognition may also come from an outside source such as friends, family members, health professionals or even places of employment who might suggest or refer an individual to seek out mental health resources. There have been limited studies within the Muslim population that touch on problem recognition, mostly focusing on how Muslims conceptualize mental health issues and suffering (Bagasra & Mackinem, 2014; Mudryk & Johnson, 2023).

The second stage, the decision to seek help, may be influenced by personal beliefs about mental health disorders, mental health stigma, cultural influences, financial barriers to help-seeking, and attitudes toward helping professionals and services. Attitudes toward services may in turn be influenced by factors such as fear of experiencing bias from providers or being misunderstood because of cultural or religious background. Many of the existing studies within the Muslim American community focus on barriers to help-seeking such as stigma (Zia & Mackenzie, 2024) or low mental health literacy (McLaughlin, Ahmad & Weisman de Mamani, 2022). Lastly, service selection within the Muslim American community may be influenced by preferences for same gender, same race/ethnicity, and even same religion or cultural

background providers, or services that demonstrate cultural competency (Shafi, 1998). Service selection can also include preferences for face to face or virtual interaction with a service provider as well as the type of therapy they are willing to participate in. Service selection within the Muslim community has also largely been ignored in the literature, with a few studies looking at the role of mosques or religious leaders in service selection.

Thus far, no study has sought to examine what these three stages of help-seeking pathways look like for Muslim Americans who have used any services, for any length of time, specifically to address mental health issues. This study seeks to explore service usage and the steps prior to service usage including provider preference in order to better understand aspects of the help-seeking process within the Muslim American community. The primary research questions of this study are: 1) What does problem recognition look like for Muslim Americans who have used any services to address mental health concerns? 2) What provider preferences are exhibited by Muslim Americans utilizing mental health services that may impact the decision to seek help? and 3) What services are most used by Muslim Americans to address their mental health concerns? Utilizing the findings from these three questions, the researcher seeks to formulate a conceptual model of the help-seeking pathway within the Muslim American community.

Methods

Participants were recruited for this study through Qualtrics Survey Panel. Qualtrics invited participants from their pool of respondents to participate in the study, aiming for a representative national sample of those who meet the study criteria. Screening questions for this study included being 18 years of age or older, identifying as a Muslim American, and having used some form of mental health services at least once in their lifetime. Participants were from all regions of the United States with the majority located in the Southeast (32%), Midwest (18%) and New England/Northeast Regions (17%). The study was approved by the Kennesaw State

University institutional review board (IRB-FY23-167) following all guidelines for conducting ethical research with human participants. Participants indicated consent by clicking that they have read the consent cover letter, meet study criteria, and agree to participate in the study. No signatures or identifiable information was collected. The survey took approximately 10-15 minutes to complete and collected no identifiable information from participants. The survey consisted of 32 questions including an attention check question. This included a demographic section, the Acculturation Scale for Muslim Americans (ASMA), questions about referral to mental health services and reasons for seeking services if not referred (self-recognition of a need for help), questions addressing preferences for service providers, and a section on the type of service, modality of service utilized and length of services (service selection). Descriptive statistics and correlations were generated using IBM SPSS Statistical applications.

Results

Three hundred and twenty-five participants (male = 141, female, 181, non-binary =3) ranging in age from 18- 68 (M=32.3) completed the survey. Almost all participants (96.9%) said they were born in the United States. Most held at least a high school diploma and consider themselves to be moderately religious (43%). Due to the small number of participants born outside of the U.S., acculturation was not scored (See Table 1 for full demographics). The majority (89.8%) had health insurance coverage, while only 68.3% were sure they had behavioral health insurance coverage.

Table 1: Demographic Characteristics of Participants

Study Sample Characteristics	**N**	**%**	**M**	**SD**
Age	323		32.3	10.41
Gender				
Male	141	43.4%		
Female	181	55.7%		
Non-binary	3	.9%		
Born in the U.S.				
Yes	315	96.9%		

No	10	3.1%		
Education				
Less than H.S.	7	2.2%		
High School	62	19.1%		
Some college	76	23.4%		
2 year degree	46	14.2%		
4 year degree	74	22.8%		
Professional degree	46	14.2%		
Doctorate	14	4.2%		
Income				
Less than $10,000	23	7.1%		
$10,000-$59,999	161	49.5%		
$60,000-149,999	99	30.4%		
More than $150,000	35	10.8%		
No income	7	2.2%		
Marital Status				
married	126	38.8%		
widowed	5	1.5%		
divorced	11	3.4%		
separated	9	2.8%		
divorced	174	53.5%		
Race/Ethnicity				
White (non-Hispanic)	72	22.2%		
Black/African-American	95	29.2%		
South Asian	30	9.2%		
Middle Eastern/North African	67	20.6%		
East Asian/Pacific Islander	8	2.5%		
Native American/Alaskan	2	.6%		
Mixed Race	22	6.8%		
Hispanic White	19	5.8%		
Hispanic Black	10	3.1%		
Health Insurance Coverage				
Yes	292	89.8%		
No	24	7.4%		
I'm not sure	9	2.8%		
Behavioral Health Insurance Coverage				
Yes	222	68.6%		
No	60	18.5%		
I'm not sure	42	12.9%		
Religiosity				
Non-practicing	12	4%		
Spiritual but not religious	38	12%		
Low religious practice	50	15%		
Moderate religious practice	141	43%		
Very religious/orthodox practice	82	25%		
Other	2	.6%		

Problem Recognition

In this study problem recognition was measured in two ways. The first focuses on whether they were referred to mental health services, which indicates problem recognition from an external source. Thirty three percent were referred to mental health services and 67% did not receive a referral. Of those who were referred 62% were referred by their doctor, 16% by an imam or spiritual leader, 17% by a family member or loved one, 1% by their job, and 4% by another source which included the courts. The second aspect of problem recognition was self-identification from the participants of the primary reason they sought out services. Twenty-two percent indicated they were having difficulty carrying out daily activities, which prompted them to seek out help. The next two reasons for help-seeking were experiencing discrimination that they found distressing (18%) and grief (17%). Twelve percent indicated they were referred and that was their primary reason and 12% were experiencing relationship issues. Less common reasons were suicidal thoughts (11%), substance abuse (7%) and other reasons (3%). Other reasons included the sudden onset of the Palestinian conflict, post-partum anxiety, behavioral issues related to Autism, anger issues, and being assaulted.

Decision to Seek Help

Within the second step of the help-seeking pathway, the decision to seek help, we were interested in provider preferences and availability of those who met their provider preferences. Contextual factors that may have also influenced decisions to seek help include stigma and fear of bias. Sixty four percent strongly agreed or agreed they preferred a same gender provider. Similarly, 56% strongly agreed or agreed they preferred a same race provider and 57% a same religion or cultural background provider. Sixty eight percent strongly agreed or agreed that they found a provider that met their preferences, while 18% neither agreed nor disagreed with this statement, 11% disagreed, and 4% strongly disagreed that they found a provider who met their preferences. More than half of all participants were worried about bias on the part of the provider prior to seeking out mental health services (56%) and 57% were worried about being

misunderstood because of their religious or cultural background. There was a slight correlation (r(325) =.350, p= .001) between worrying about bias of the provider and keeping service usage a secret in this study.

Service Selection

The type of provider, type of mental health service, mode of service, and length of service used were measured. The majority of participants saw their primary health care provider (44%) followed by 24% who saw a combination of more than one service provider and 21% who saw a licensed counselor, therapist or psychologist/psychiatrist. Eight percent of participants were unsure who they saw, while 2% saw a licensed social worker and 1% used another service which was identified as 24/7 hotlines and University counseling centers. More than half (52%) indicated that they participated in some form of talking therapy (psychotherapy). Fifteen percent attended grief counseling and 12% participated in marriage or family therapy. Seven percent participated in CBT while 5% primarily received substance abuse/detox treatment. The remaining participants were involved with art therapy (4%), treatment of a phobia (2%) or another form of treatment (3%). For mode of therapy, 75% of individuals engaged in face-to-face services. Thirteen percent were video visits, 9% phone visits, and 3% were by text. Length of use of mental health services varied from less than one month (15%), less than six months (24%), six months to a year (26%), more than a year (15%) to those who are still using services (17%) at the time of study participation. Of the 3% of participants who indicated other, most indicated they used the service once or twice only.

Experiences with Services

The majority of the participants in this study received a formal diagnosis as part of the services they used (57%), and almost as many (51%) received a prescription medication. In terms of their personal experiences with using mental health services 29% strongly agreed that it was a mostly positive experience, 49% somewhat agreed, 19% neither agreed or disagreed that their

experience was mostly positive, 3% somewhat disagree and 1% strongly disagreed that their experience was mostly positive. Despite the majority of participants agreeing they had a mostly positive experience with a mental health service, 53% kept use of that service a secret from their family and friends.

Discussion

This study applied an existing help-seeking pathway model (Cauce et al., 2002) to explore help-seeking pathways of Muslim Americans who have used or are currently using some form of mental health services. A conceptual model of help-seeking pathways for Muslim Americans is proposed based on the findings from this study (See Figure 1). Stage 1 begins with an individual's experiences of personal distress, and how they may interpret these experiences. The second stage is recognition that their experience may require outside help. At that stage, they may engage in self-recognition, or they may be referred by a family member, friend, job, or other sources that encourage (or mandates) help-seeking. After recognizing that their distress may be alleviated by seeking outside help, they may engage in a period of information-seeking which may be mitigated by their knowledge of mental health, personal attitudes toward mental health services, and self or community stigma regarding mental and emotional distress. They may then identify service preferences and engage in service selection. Their experiences with mental health services will impact future decisions to seek help. Findings suggest that despite continued stigma (measured as keeping service usage a secret) and fear of bias or being misunderstood by mental health service providers, Muslim Americans who have used some form of service to address mental distress report mostly positive experiences with services that they have used. This differs from previous studies that reported perceived low cultural competence or bias among mental health providers working with Muslim clients (Reich, Jarvis & Whitley, 2024; Bagasra, 2023). Primary care doctors continue to be the first source of help, most likely because there is less stigma associated with seeing a physician than a counselor or

psychologist. Provider preference findings support previous research that suggests a preference for similar gender, race or culture provider (McLaughlin, Ahmad & Weisman, 2022; Shafi, 1998). Family members and Imams were the next two groups who referred individuals to mental health services the most after primary care doctors, supporting previous research showing a preference for imam collaborations (McLaughlin, Ahmad & Weisman, 2022). The study also revealed that many Muslim Americans seek out mental health services for reasons outside of traditional diagnosable mental illness including experiences of discrimination, relationship problems, and grief. Raising awareness that these are legitimate reasons to seek out services may be an important way to reduce distress in a community that continues to experience rising rates of discrimination. Incorporation of marriage and family therapy and premarital therapy in partnerships with mosques may also increase access and usage of these services.

Study Implications

Findings from this study continue to support the need for availability of therapists and other helping professionals who have similar religious and cultural backgrounds as their clients. The availability of Muslim behavioral health professionals in a variety of settings would most likely increase service usage. Face to face (in person) services in particular, that include some form of psychotherapy, appear to best support the needs of Muslim Americans from a variety of backgrounds. The study also shows that despite engaging in help-seeking behaviors, many participants still kept their usage a secret from family and friends, indicating that we need to engage in anti-stigma campaigns and mental health literacy within the Muslim community to reduce both self-stigma and stigma associated with Islamophobia that has been found to be a major barrier to help-seeking (Alhomaizi et al, 2018; Zia & Mackenzie, 2024; McLaughlin, Ahmad & Weisman, 2022). Primary health care providers continue to be the main source for both referrals to mental health services and the first source of assessment, diagnosis and treatment, despite the fact that primary care doctors may receive little continuing education in

mental health and psychopharmacology. Mandatory annual mental health continuing education hours for physicians would better prepare primary care physicians for the front-line role the appear to take for Muslim Americans experiencing psychological distress. Increasing religious and spiritual competency training for primary care physicians could lead to additional service usage within this population. APA guidelines for religious and spiritual competencies (Vieten & Lukoff, 2021) highlight the need for this type of training to increase the level of comfort among many religious individuals to seek out mental health services. A few religious and spiritual competency training courses have been developed (Pearce, Pargament, Oxhandler, Vieten, & Wong, 2019; Hull, Suarez & Hartman, 2016) and additional trainings specific to individual religious traditions are in development. This study did not ask about preference for Islamically-integrated treatment options, which could be a direction for future studies as an additional preference question. Islamically-integrated psychotherapy is a growing field with a number of Muslim practitioners incorporating it into their practices and demonstrating promising outcomes for religious Muslim clients (Khan et al., 2023; Munawar, Ravi, Jones & Choudhry, 2023; Mahmoodi, Akhavan & Virk, 2023).

Limitations

An unusually large number of participants in this study identified as U.S. born Muslims, which may have to do with the use of Qualtrics survey panel for data collection. Internet-based survey collection sites tend to be used by younger, highly educated individuals with consistent internet access and smart phone usage. Unlike previous studies with high South Asian Muslim participation, participants in this study were comprised mostly of individuals self-identifying as White, African American/Black, or Middle Eastern/North African (MENA). Individuals who are highly acculturated and have knowledge of mental health services are more likely to utilize services, which is reflected in the demographics of the study population. U.S. born Muslims are more likely to have high mental health literacy compared to immigrant Muslims. Examining the

help-seeking pathways inclusive of immigrant, refugee, and elderly Muslim Americans is essential to developing a more holistic approach to help-seeking within the community.

This study had a question allowing participants to discuss their experiences in more depth, but few participants utilized the open-ended response option. Qualitative data on the steps between problem recognition and services usage, including how long it took between these two stages would contribute further to understanding the links between each stage of the help-seeking pathway. This study also did not measure prior knowledge of mental health services, attitudes toward mental health professionals and conceptions of mental illness, which may contribute to each stage of the process and are listed as precursors to Problem Recognition in the proposed model. Future research should expand on the present study by including questions that measure these contextual factors. Additionally, future research must reach more immigrant and refugee Muslims, a population likely to experience acculturation stress and discrimination.

This study highlights the necessity of identifying help-seeking pathways within traditionally marginalized populations and acknowledging the many factors that influence help-seeking behavior. Developing a conceptual model of help-seeking based upon the lived experiences of Muslim Americans provides a framework for further strategies to increase service utilization, reduce stigma, and reflect on client experiences with services and providers.

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