Issues to Consider When Engaging Muslim Youth in Psychiatric Care

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Disclosures

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Educational Objectives

1. Attendees will be able to identify key characteristics of American Muslim Youth and address the potential impact of religion, culture and immigration status on their mental health.

2. Attendees will be able to identify 3 types of cultural and religious stresses experienced by American Muslim Youth in their daily lives. These may include acculturation, stigma, prejudice, immigration status, cognitive dissonance and language barriers.

3. Attendees will be able to name 3 evidence-based mental health interventions appropriate to the mental health care of American Muslim Youth and their families.
Overview

- Introduction
- Vignettes
- Principles in working with Muslim Youth in Psychiatric Care
- Points to Ponder
- Discussion
“Say Hi to Osama”

“My teacher called me Osama Bin Laden while taking roll-call…every day”

“Go back to where you came from”

“You go to the mosque and everything, When you go, do you hear anything like when and where the next bombing’s going to be?”

“Don’t you feel hot in that thing you wear (hijaab)”

“Condemnations are not enough…Muslims need to do more”
Washington, DC, February 1, 2017 – Representing over 9,200 members, the American Academy of Child and Adolescent Psychiatry (AACAP) is a professional organization dedicated to promoting the healthy development of children, adolescents, and families. Our membership includes physicians from 61 countries, and we treat the youngest patients across America without regard to their race, religion, ethnicity, or immigration status. We view children's mental health as a non-partisan issue that affects every family in the United States, and we eagerly share our expertise with any government official or agency seeking to protect the mental health and well-being of children, youth, and families.

Recent Executive Orders on immigration are at odds with the fundamental mission and values of AACAP. We are especially concerned because our members are telling us stories of children coming in for treatment who are expressing fear and anxiety about the possibility of their parents being deported or not being allowed back in the country after traveling. We also have heard about a young child being separated from his parents at the airport. What is a relatively brief separation in the eyes of adults can leave indelible scars on the psyche of a developing child. Chronic anxiety, feelings of not belonging or being wanted, and bullying can permanently damage children's brains, development, and their future potential.

A significant number of AACAP's physician members are international medical graduates who are training or practicing in the United States and came here as immigrants from other countries. Their cultural diversity, work ethic, and commitment to their patients and families enhance our child and adolescent psychiatry workforce, which is in severe shortage and is presently inadequate to serve the needs of America's children. Without child and adolescent psychiatrists coming from other countries, access to needed mental health services would be impossible in many areas of the United States. These devoted professionals deserve our support and gratitude for their commitment to serving America’s children.

Our knowledge, compassion, and clinical expertise are hallmarks of AACAP membership, and our comments are offered to advance pediatric mental health. As always, we urge our AACAP members to advocate for their patients and colleagues on matters of public policy by contacting their elected representatives.

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Representing 9,200+ child and adolescent psychiatrists nationwide, the American Academy of Child and Adolescent Psychiatry (AACAP) is the leading authority on children's mental health.
Vignette 1:

R, Age 16, High school student

- Recently immigrated from Pakistan
- Preconceived ideas about how Muslims were viewed in the US
- Considered concealing her Muslim identity
- Victim of bullying; targeted for being Muslim
- Reporting to authorities seemed to “worsen the hostility”
- Microaggression
- Invalidated; told that she was “too sensitive” or “paranoid”
Racial Microaggression
Subtle forms of discrimination (often unintentional and unconscious) that send negative and denigrating messages to members of marginalized racial groups.
Vignette 1

- Resentment towards parents; decreased communication
- Somatic symptoms, school refusal
- Academic and social decline
- Conflicted between holding on to her religious and cultural identity and “fitting in”
Vignette 2:

- S, 16 yr old, High school student
- Born and raised in the US; parents immigrated from Morocco
- Mother is an Arabic teacher
- Family very involved in local mosque
Vignette 2

- Feels that mom is critical of her friends and doesn't trust her

- Mom insists on buying “Dowdy” clothes;

- Often changes clothes once she leaves the home; feels like she is leading a “double life”

- Feels guilty but wants to fit in and be included

- Does not want to try drugs/alcohol but worries about being considered a “party pooper”
Vignette 3

- 20 yr old Muslim male, migrated to the US at age 11
- Bullied in middle school; "terrorist" written on his backpack.
- Peers made thinly-veiled comments regarding Islam, laughed off as 'jokes'
- Made fun of being 'the virgin'
- Struggling with the desire to be sexually active.
- Guilt about these thoughts.
- Peers experimenting with drugs and alcohol
- Conflicted between the temptation to give in to the impulse to use substances and the fear that he would be committing a sin and cheating his parents.
Vignette 3

- Has to make it a point to condemn news of a terrorist attack to prove that he does not support it.
- Muslim Student Association
- Seem to avoid discussing what he believes are the “real issues”.
- Victims of Islamophobia are hesitant to bring it up, even amongst other Muslims because they would prefer to stay out of the limelight.
Being a Muslim Physician in the US

- Muslim physicians from diverse backgrounds comprise 5% of the U.S. physician workforce

- There is limited research examining how religious identity can cause discrimination

- Evidence suggests that Muslim physicians do experience religious discrimination at work

“Am I Passing?”

- Muslims that are less traditional and may not wear religious garments at all (or only on holidays) may have different experiences than Muslims who wear traditional clothes on a regular basis.

- The idea of “passing” was introduced in the literature on multiracial microaggressions citing that when an individual is mistaken or “passes” for the dominant group, she or he may be afforded more privilege than those who do not (or cannot) pass.

Principles for working with Muslim patients

Principle 1: Clinicians should consider and address language/communication barriers for Muslim youth who seek psychiatric care.

- This is a diverse group from many different ethnic backgrounds speaking many languages.
- This reinforces the importance of the translator, interpreter, and cultural consultant when interacting with this population.
- Obtain linguistic support through qualified interpreters.
- Avoid Language brokering

Principle 2: Clinicians should learn about the importance of acculturation and immigration status of Muslim youth

- The more recent the immigration, the greater the risk of acculturative stress.
- Associated with discrimination, stereotyping, racism, marginalization, and prejudice.
- Refugees are escaping ethnic, cultural, or religious persecution, civil war, and international conflict.
- In search of economic and educational opportunities, to reunite with family

Principle 3: Clinicians should recognize culture-specific stressors experienced by Muslim youth and avoid negative stereotypes.

- Increased and even extreme prejudice and discrimination following 9/11
- Harassment, hate crimes, reports of bullying at school, attacks on Muslims’ place of worship (mosques), and attacks on women wearing hijab.
- Resulting in anger among some Muslim youths and confusion among others. Clinicians need to be aware of such dissonance and must explore social, religious, cultural factors when assessing Muslim youth patients.

Principle 4: Clinicians should demonstrate humility and respect when they address cultural differences in clinical encounters with Muslim youth.

- Give the client the option of integrating religious and traditional healing practices into the therapeutic process.
- Muslim youth experience an intersectionality of complex relationships between different identities (e.g., race, gender, sexual orientation, class, and disability).

Principle 5: Clinicians should understand the dynamics of the parent-child relationship and family characteristics that contribute to both strengths and vulnerabilities of Muslim families.

- One of the most important features of Muslim society is the family. The family unit is regarded as the cornerstone of a healthy and balanced society.
- Many families would prefer to seek support from other family members, the community, or religious leaders for their child’s mental illness to avoid the stigma of mental illness.
- Clinicians should not be surprised if multiple family members attend sessions.

Principle 6: Clinicians should appreciate the role of intra-cultural coping in Muslim youth.

- Due to the lessened stigma of physical symptoms, mental health problems are often expressed as physical symptoms.
- Normative cultural beliefs in existence of Jinn (evil, Satan-like spirits) may be confused with delusions of possession and control.
- Belief in Qadr, or destiny, is strong; suggests positive acceptance of God’s will and higher levels of optimism with respect to healing.

Principle 7: Clinicians should determine whether home and community-based therapeutic interventions can be used as alternatives to hospitalization for Muslim youth.

- The role of family and religion in the intensive care of Muslim youth with severe mental illness requires the clinician to be particularly attentive to critical related issues such as language needs, gender roles, family hierarchy, family history, and spiritual practices.

- It is important to pay attention to gender roles (e.g., pairing a female client with a female counselor) and the family hierarchy (e.g., not undermining a dominant father when providing a family intervention involving children.)

- Psychoeducation is a priority. The majority of Muslim immigrants come from countries where mental health services are reserved for the severely mentally ill and involve hospitalization.

- Clinicians also should be aware of traditional healing as another model of Islamic counseling.

Principle 8: The Role of Mosques and Imams

- Typically, Muslims first come to the mosque and seek out their Imam when they face problems.
- The main role of Imams for Muslims is to provide advice which is in accordance with the Qur’anic principles and teachings of the Prophet Mohammad.
- Muslims approach Imams for counseling for social and mental health issues and, particularly, marital and family problems.
- The Imam’s role is in part to meet the counseling needs of the Muslim community.

Principle 8: The Role of Mosques and Imams

In order to minimize disparities of mental health care to the growing Muslim population in the United States, community healthcare planners need to appreciate that Imams are (a) an important source of referrals and influence on the attitudes toward mental health and help-seeking within their communities; (b) able to recognize serious mental health problems; and (c) appear more willing to collaborate with mental health professionals if they have had previous consultation experiences.

Principle 9: Clinicians should be aware of the need to adapt evidence-based treatments (EBTs) with Muslim youth

- For most Muslim patients, modified short-term psychodynamic therapy is a better choice than classic long-term psychoanalysis.
- Focusing on family dynamics, conflicts, and relationships is also helpful and is recommended over focusing on intrapsychic conflicts.
- In addition, therapy should be aligned with the patients’ religious beliefs and cultural values.

Principle 9: Clinicians should be aware of the need to adapt evidence-based treatments (EBTs) with Muslim youth

1. Cognitive-behavioral therapy (CBT), Solution-Focused therapy, modeling and behavioral techniques, including behavioral modification, systemic desensitization, and flooding, have all been shown to be effective when treating Muslim patients.

2. For African American Muslim youth and traumatized immigrant youth, trauma-informed treatment is an important foundation for effective mental health care.

Principle 10: Clinicians should assess the use of electronic/social media.

- A Clinical Report from the American Academy of Pediatrics cited both benefits (socialization/communication, enhanced learning opportunities and accessing health information) and risks (cyberbullying/online harassment, sexting, Facebook depression, privacy concerns/digital footprint, and influence of advertisements).

- As with all other patients, clinicians have to remain cognizant of the use of social media when engaging Muslim youth in psychiatric care.

- Like their counterparts, many Muslim youth spend much of their time on social media and prefer popular apps such as Snapchat and Twitter. However, some Muslim youth seek an escape in the online world, which can leave Muslim youth feeling marginalized and demoralized.

Principle 11: Clinicians should assess for a history of loss, trauma, and/or community violence in Muslim youth.

- Certain Muslim youth groups (African American, Refugee, and Immigrant) are at higher risk for a variety of traumatic events, such as physical and sexual abuse, witnessing domestic and community violence, separation from family members, and re-victimization by others.

- Also, the stress of assimilation and acculturation (often with downward social mobility for immigrant families), negative stereotyping, and cultural acceptance of corporal punishment of women in patriarchal family structures increase the risk for trauma reactions.

- One in four Muslim students reported that they “often or always” experience stress at school, while three in four students described having been “really stressed out” at some time in the past 12 months.

- Seeking consultation and collaboration with specialists and community members is more often than not an expected feature of practice.

POINTS TO PONDER

- Muslim youth may be particularly vulnerable to issues related to acculturation.

Transition to adapting to a new culture’s behaviors, values, customs, and language

- Diversity amongst individual experiences based on gender, social environment, first vs second generation immigrants, residency status and expectations for life in the new culture

- Shared / Common themes
Muslim youth often struggle to **achieve a balance** between their family’s religious and cultural values and American mainstream trends, values and lifestyles.

They may lead **double lives**, which can be a source of additional stress in a vulnerable period of their lives, when they are making a transition from childhood to adulthood.
Points to Ponder

- Many Muslim parents may feel a religious obligation to protect their families from cultural values different from their own.

- Expect their children to comply with religious/cultural norms, for example with regards to dress code, food habits and socialization, which can cause conflict.

- These youth may often experience guilt and resentment about having to hide certain aspects of their lives from their parents while they try to fit in with their non-muslim peers.
Points to Ponder

- Muslim youth, may not feel comfortable working with non-Muslim therapists or mental health providers who they feel do not understand Muslim culture or the religious contexts of Muslim issues.

- Amongst several Muslim communities, the imam (i.e., the one who leads the prayer at a mosque and/or is an Islamic scholar) addresses the mental health problems of the members.

- Youth may not feel comfortable discussing topics that are considered taboo such as issues related to sexuality and dating, with someone who is usually considered to be a religious authority figure.
Muslim youth may feel marginalized, isolated and misunderstood because of the stereotypes, prejudices and myths about their religion and its practices.

Immigrant youth in particular, may lack a sense of belongingness and feel unaccepted by peers because of their different cultural values and practices.

They may find it difficult to fit into both worlds and cultures and feel that they do not belong to either.

Acculturation stress can negatively impact the academic, social and occupational functioning of Muslim youth and can also present in the form of somatic complaints.
'In-Betweeners'

“YOU ARE NOT MUSLIM OR AMERICAN; YOU ARE MUSLIM AND AMERICAN”
Barack Obama, Feb 2016
COUNSELING MUSLIMS
HANDBOOK OF MENTAL HEALTH
ISSUES AND INTERVENTIONS
EDITED BY
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