Chapter 55

Religious Coping Among Muslims With Mental and Medical Health Concerns

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ABSTRACT

Studies suggest that a lack of understanding and sensitivity around religious issues by healthcare professionals may be a noteworthy barrier for Muslims seeking treatment. One way to help bridge the gap between Muslims' healthcare needs and healthcare utilization rates may be through fostering awareness and sensitivity about the influence of Islam on how Muslims cope with their illness experience. Using a biopsychosocial-spiritual theoretical framework, a main aim of this chapter is to consider a variety of ways that Muslims use religion to cope with physical and mental health challenges. Religious coping can take a variety of forms: Positive religious coping involves making use of Islam in beneficial manners. Negative religious coping, referred to here as r/s struggles, often involves tension or conflict regarding matters of religion. Understanding the role that religion/spirituality can play in how Muslims cope with their physical or mental illness may help to foster higher quality, more culturally sensitive care. Recommendations and limitations are discussed.

INTRODUCTION

A growing body of literature suggests that people often turn to their spirituality and/or religious beliefs when coping with a stressful life event (e.g., Ano & Vasconcelles, 2005; Jim et al., 2015; Pargament, 1997). This may be particularly true among individuals who identify religion and/or spirituality as a salient component of their identity (Pargament, Tarakeshwar, Ellison, & Wulff, 2001). As most research

on religious coping has been conducted among Christians in the United States, there is a dearth of scholarly work that examines the important role that Islam may play for U.S. Muslims dealing with a mental health or medical illness. Thus, the primary purpose of this chapter is to consider the variety of ways that Muslims may use religion to cope with physical and mental health challenges.

Muslims constitute nearly one-fourth of the world's population and form the second largest religion in the world (Hackett & McClendon, 2017). Despite the current and projected rapid growth (Lipka & Hackett, 2017) of this population, Muslims continue to represent an understudied and underserved heterogeneous group of individuals. This is particularly true in the field of healthcare (Tackett et al., 2018). For example, researchers examining breast cancer screening practices among South Asian and Middle Eastern Muslim women found that only 52% of the participants indicated utilization of mammography services (Hasnain, Menon, Ferrans, & Szalacha, 2014), a percentage that is substantially lower than recent data gathered from a national health survey suggesting that about 72% of women in the United States received a mammogram within the past two years (Hall et al., 2018). Such results from the United States are comparable to findings from places around the world where Muslims may be in similar minority status (Gyimah, Takyi, & Addai, 2006).

In terms of mental health, researchers conducting a study among Somali, Palestinian, and Egyptian community members and college residents ($N = 276$) found that about 90% of the participants reported no utilization of mental health services in the past three years (Aloud & Rather, 2009). Likewise, Muslim immigrants with Obsessive-Compulsive Disorder (OCD) reported between 5-13 years between symptom onset and seeking professional help (Mahintorabi, Jones, & Harris, 2017).

A number of factors may influence and contribute to the low rates of healthcare seeking behaviors among Muslims not only in the United States but also in other places around the world where Muslims are a minority group (e.g.,.Gyimah et al., 2006). First and foremost, Muslims may lack understanding and familiarity with the healthcare system (Hasnain, Connell, Menon, & Tranmer, 2011) or lack trust towards providers (Hasnain et al., 2011). Furthermore, both qualitative and quantitative studies suggest that many Muslims report feelings of perceived discrimination in healthcare (Martin, 2015; Vermette, Shetgiri, Al Zuheiri, & Flores, 2015). The lack of same-gender providers (McClean et al., 2012; Padela & del Pozo, 2011) and stigma associated with seeking help (Youssef & Deane, 2006) have also been proposed as factors that reduce health service utilization by Muslims. On a similar note, qualitative responses regarding cervical cancer screening suggest that Muslims' values may often differ from traditional values of Western medicine (Matin & LeBaron, 2004). Specifically, feelings of discomfort surrounding modesty concerns have been found to be associated with delayed healthcare seeking (Vu, Azmat, Radejko, & Padela, 2016).

Above all, multiple studies have suggested a lack of understanding, sensitivity, and competency regarding cultural and religious issues to be a noteworthy barrier in seeking medical and mental health treatment among Muslims (e.g., Hasnain et al., 2011; Padela & Zaidi, 2018; Weatherhead & Daiches, 2010). For example, a semi-structured interview with a heterogeneous Muslim sample revealed the inclusion of religious and cultural values to be an important component of the therapeutic discourse and relationship not only to better understand the individual but also for the provider to ask well-informed questions (Weatherhead & Daiches, 2010). Likewise, Muslim women have reported feeling misunderstood by healthcare practitioners regarding their religious needs, which can be a barrier to maternity health care services (Reitmanova & Gustafson, 2008).

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