Mental Health Service Utilization and Psychological Help-Seeking Preferences Among Canadian Muslims

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ABSTRACT

Muslims in Canada may have unmet psychological service needs, but little is known about their past use of, and future preferences for, mental health services. We addressed this gap with an online survey of 238 Canadian Muslims. Analyses investigated differences in intentions to seek support from various informal and formal sources. A majority (65%) of the sample reported at least moderate levels of current distress but only 48.7% sought professional treatment in their lifetimes. Participants preferred dealing with future psychological concerns themselves or with friends/family, closely followed by professional help. Imams were the least preferred source of support.

Keywords: Muslims; service use; mental health help-seeking preferences; psychological distress; Islamophobia

RÉSUMÉ

Au Canada, certains musulmans ont pu rencontrer des difficultés pour obtenir des services psychologiques répondant à leurs besoins. Mais leurs expériences passées et leurs attentes en ce domaine sont peu documentées. Nous avons donc analysé la situation à la faveur d'un questionnaire en ligne auprès de 238 Canadiens musulmans. Il s'agissait de préciser les différentes manières informelles ou non de rechercher du support. Une majorité (65 %) des répondants a rapporté au moins un niveau modéré de détresse courante, mais seulement 48,7 % ont eu recours à des traitements professionnels durant leur vie. Dans l'ordre, les participants préféraient traiter leurs problèmes psychologiques éventuels par eux-mêmes ou à

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l'aide d'amis ou de membres de la famille, suivi de près par l'aide d'un professionnel. Les imams étaient considérés comme la source de soutien la moins recherchée.

Mots clés : musulmans, utilisation de service, soutiens recherchés en santé mentale, détresse psychologique, islamophobie

As religious and ethnic minorities, Muslims living in Western countries (i.e., Canada, the United States, Australasia, and Europe; Kurth, 2003) often face circumstances such as discrimination which can lead to the development of psychological problems (Environics Institute for Survey Research [EISR], 2016; Youssef & Deane, 2006). Investigations of Western Muslims' psychological concerns, both in terms of prevalence and service utilization, are limited. Existing reports focus on Australian Muslims and suggest that this population has significant unmet needs for psychological services (Kayrouz et al., 2015; Youssef & Deane, 2006). These limited findings suggest that other Western Muslim populations, including those living in Canada, may also have unmet psychological service needs. Therefore, an exploration of Canadian Muslims' psychological service needs and preferences is warranted.

Canadian Muslims, like other Western Muslim populations, face several significant challenges that increase their risk for psychological distress (i.e., symptoms of anxiety and depression) and mental disorders (e.g., major depression, general anxiety disorder). One such challenge is that the majority of Canadian Muslims are immigrants (EISR, 2016) and often face difficulties with migrating and adjusting to Canadian norms (Akram-Pall & Moodley, 2016; Barkdull et al, 2011). A large proportion (70%) of Muslims living in Canada have favourable attitudes toward integrating into Canadian culture (EISR, 2016). Nevertheless, these individuals report concerns related to immigration, including integrating into an unfamiliar culture, unemployment, and navigating language barriers (Akram-Pall & Moodley, 2016). Due to the often-universal challenges with immigration in this immigrant-majority population, psychological difficulties may be highly prevalent.

A second mental health challenge facing Canadian Muslims is that Islamic beliefs and norms are often misrepresented in Western media, resulting in negative portrayals of Muslims and subsequent discrimination against them by media consumers (Barkdull et al., 2011; El-Aswad, 2013; Jisrawi & Arnold, 2018). Indeed, Muslims living in Western countries are increasingly the victims of violent hate crimes. For example, in 2017, a mosque in Québec, Canada was the target of the deadliest mass shooting in a place of worship in Canadian history, and a 2021 vehicular terrorist attack in London, Canada took the lives four members of a single Muslim family. While research has not specifically explored the psychological aftereffects of these attacks, Islamophobia is an established contributor to psychological concerns among Muslims living in Western countries (Samari et al., 2018).

As a result of issues such as immigration and discrimination that can result in clinically significant mental health problems, Muslims living in Canada may need mental health services. Yet it is unclear whether these needs are being met. Given that immigrants comprise a substantial majority of Canada's Muslim population, and that immigrants tend to underutilize psychological services (Derr, 2016), Canadian Muslims may be unlikely to access psychological services. In analogous studies of another Western Muslim population,

Arab Australians underutilized community mental health services despite a greater need for services than the general population (Kayrouz et al., 2015; Youssef & Deane, 2006). However, because Arabs account for only one quarter of Muslims living in Canada (EISR, 2016), research is warranted exploring this population's mental health service needs in an ethnically diverse sample.

Researchers have speculated that Muslims living in Western countries may be unlikely to seek services from psychological professionals (Amri & Bemak, 2013; Abu-Ras et al., 2008). In addition to common barriers such as the fear of discrimination (e.g., losing employment) for having a mental health problem (Corrigan, 2004), the stigma of seeking psychological help among Western Muslims may prevent them from seeking services (Ciftci et al., 2013; Amri & Bemak, 2013; Zia & Mackenzie, 2021). Additional factors such as cultural mistrust of psychotherapy or experiences with discrimination have also been proposed as factors that may prevent some Western Muslim populations from seeking formal psychological services (Amri & Bemak, 2013). Some researchers speculate that Muslims may prefer to seek help from non-professional sources such as family and religious leaders (Abu-Ras et al., 2008). Other findings suggest that educated, urban-dwelling immigrants may be willing to utilize psychotherapy (Gorkin & Othman, 1994), and that Canadian immigrants from the Middle East and North Africa may be more likely to utilize mental health care compared to other immigrant groups (Durbin et al., 2015). To address these differing perspectives, the present study is among the first to explore the relationships between mental healthcare needs, utilization, and intentions to seek services among Muslims living in Canada. Given reports that Canadian Muslims are generally highly educated (EISR, 2016), we hypothesize that Canadian Muslims will have stronger intentions to seek services from health professionals than from imams. Moreover, we hypothesize that help-seeking intentions will be strongest from informal sources (dealing with it oneself or through friends and family).

METHODS

Participants and Procedures

In 2018/2019, Canadian Muslim adults were recruited to participate in an online survey hosted on the Qualtrics web-based research platform, investigating psychological help-seeking attitudes and intentions. All procedures and materials were approved by an institutional research ethics board. Muslim community organizations (e.g., mosques, community centres, non-profits) in major metropolitan areas across Canada were contacted by email to request dissemination of study advertisements. Participants were recruited via existing email listservs and social media accounts managed by the community organizations that chose to participate. Recruitment ads also directed participants to forward the survey to other Muslim adults in their communities. Eligible participants were Canadian citizens or residents, self-identified as Muslim, and were able to read and write in English. Of the 366 participants who responded to the ads, 125 did not complete the survey, one person was removed for failing attention check questions, and two were removed because they did not identify as Muslim. The final sample included 238 participants.

Measures

Demographic information was gathered through self-report measures of age, gender, ethnicity, religious identity, citizenship status, and years spent in Canada.

Psychological help-seeking preferences were measured with five items assessing intentions to seek help if one were struggling with psychological concerns (Mackenzie et al., 2004). Four items measure intentions to manage future psychological difficulties by seeking help from a general medical practitioner, mental health professional, friends or family, and religious leader (i.e., imam). A fifth item examines intentions to deal with mental health challenges by themselves. Each item is scored on a 5-point scale (1 = Extremely Unlikely; 5 = Extremely Likely) where higher scores reflect more favourable intentions.

Religiosity was measured using the 19-item Religiosity of Islam scale (ROI; Jana-Masri & Priester, 2007). Items on the ROI are scored on a five-point scale (1 = never/strongly disagree; 5 = always/strongly agree). Due to concerns about systematic missing data from unmarried men, one item from the ROI was excluded from analyses (i.e., I wear hijab as a woman/my wife wears hijab). Total scores were computed by averaging the remaining 18 items. While the ROI has not been psychometrically assessed, its authors report associations with ratings of religious importance in one's life. The ROI had good internal consistency in the current sample (Cronbach's $\alpha = 0.84$).

Psychological distress was measured using the six-item Kessler distress scale (K6; Kessler et al., 2003). The K6 measures symptoms of depression and anxiety in the past 30 days. Items are scored on a five-point rating scale (0 = none of the time; 4 = all of the time) and a total score was computed by summing items. Cut scores ≥ 5 indicate levels of distress that are moderate but that nonetheless impact functioning and necessitate treatment, while scores ≥ 13 indicate severe distress (Prochaska et al., 2012). The K6 has good internal consistency and is sensitive in identifying severe psychological health concerns (Mewton et al., 2016). Internal consistency in the current sample was good (Cronbach's $\alpha = 0.87$).

Service use was measured using three questions modified from the National Comorbidity Survey (Kessler, 1994). Respondents answered yes or no to whether they had ever discussed psychological problems with a mental health professional, general practitioner, or an imam. The following additional item measured perceived need for mental health services: Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your emotions or nerves?

RESULTS

The current sample was composed of Canadian Muslims aged 18–70 years ($M = 36.4$, $SD = 11.9$). South Asians made up most of the sample (53.8%), followed by Arab (14.7%), African (10.5%), White (9.7%), East/Central Asian (4.6%), and other (6.7%) racial/ethnic populations. Most participants were foreign born (67%), female (69%), and moderately religious ($M = 4.13$, $SD = 0.49$). Most participants held either a graduate/professional degree (31%) or a university degree (39%); the remainder held college diplomas (9.7%), some post-secondary education (13%), or at least some high school education (7.2%). Two thirds (65.6%) of participants met clinical cut scores for moderate (47.9%) or severe (17.6%) psychological distress in the past month ($M = 7.48$, $SD = 5.14$), and 60.1% perceived the need for professional mental health services in the last 12 months. Less than half of the participants reported seeking help from a mental health professional (48.7%) or a general practitioner (44.7%) in their lifetimes, and only 21.4% reported seeking psychological help from an imam.

First-order correlations between the study variables are reported in Table 1. Of note, preference to seek treatment from a mental health professional was positively correlated with lifetime history of using services from a mental health provider, gender, and age, but not significantly associated with perceived need or psychological distress. Moreover, preferences to seek services from a general practitioner were similarly positively associated with history of seeing a general practitioner for emotional difficulties, gender, and age. However, preference for seeking services from a general practitioner was not significantly associated with perceived need, and negatively associated with distress. Preference for seeking services from imams was positively associated with religiosity and previous service use from an imam but was also negatively associated with both distress and perceived need. Similarly, preference for seeking support from friends or family was negatively associated with distress and perceived need.

Differences in intentions to seek support from various providers were tested using a one-way repeated measures, within-subjects analysis of variance (ANOVA)[1] comparing average scores on the five options in Figure 1. There was a significant main effect of intentions to seek the various types of psychological help, $F(3.47, 822.15) = 71.15$, $p < .001$, indicating that participants differed in their intentions to seek support from the various providers. Pairwise comparisons using a post-hoc Bonferroni test were conducted to determine which group means were significantly different. Group comparisons are represented in Figure 1. Consistent with our hypothesis, participants were most likely (and equally likely; $p = 1.0$) to indicate intentions of dealing with a future mental health problem by themselves ($M = 4.19$; $SD = 0.98$) or by talking to friends/family ($M = 4.09$; $SD = 1.10$). Participants were significantly more likely to deal with problems by themselves than by seeking services from a mental health professional ($M = 3.90$; $SD = 1.19$; $p = .05$), general practitioner ($M = 3.77$; $SD = 1.26$; $p < .01$), or an imam ($M = 2.71$, $SD = 1.33$; $p < .001$). Intentions to talk to a family member/friend did not differ significantly from intentions to talk to a mental health professional ($p = .65$). However, participants were more likely to report intentions to talk to friends and family than to talk to a general practitioner ($p < .05$) or an imam ($p < .001$). Additionally, intentions to talk to a mental health professional did not differ significantly from intentions to talk to a general practitioner ($p = .65$). Most notably, and consistent with our hypothesis, participants were least likely to report intentions to talk to an imam about their mental health concerns compared to all other service providers (*p*s < .001).

1. Results of Mauchly's Test of Sphericity indicated a violation of the sphericity assumption, $\chi^2(9) = 81.54$, $p < .001$, necessitating the use of a Greenhouse-Geisser correction.

Table 1

First-Order Correlations (Pearson and Point-Biserial) Between Study Variables

		1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.	Gender[1]	-													
2.	Age	-.13*	-												
3.	Education	-.04	.26*	-											
4.	Length of time in Canada (Years)	.10	.49*	-.03	-										
5.	ROI[2]	-.08	.12	.01	-.02	-									
6.	Distress[3]	-.06	-.27*	-.27*	-.29*	-.16*	-								
7.	Perceived need[4]	.10	-.23*	-.08	-.15	-.24*	.48*	-							
Preference to seek services from:[5]															
8.	General practitioner	.22*	.24*	.01	.18*	.00	-.14*	-.06	-						
9.	MH professional	.27*	.15*	.11	.17*	-.07	-.08	-.04	.61*	-					
10.	Imam	-.06	.10	-.03	-.05	.43*	-.15*	-.25*	.23*	.08	-				
11.	Family or friend	.15*	-.03	.17*	-.06	.09	-.26*	-.17*	.16*	.06	.25*	-			
12.	Taking care of it oneself	-.04	-.07	-.00	-.04	-.02	-.01	-.04	.00	-.10	-.01	.06	-		
Lifetime MH Service use from:[6]															
13.	MH service provider	.12	-.02	-.06	.09	-.16*	.23*	.35*	.02	.20*	-.17*	-.09	-.12	-	
14.	General practitioner	.00	-.01	-.04	.02	-.21*	.28*	.39*	.20*	.15*	-.04*	-.13*	-.05	.41*	-
15.	Imam	-.12	.01	-.09	-.07	.25*	.18*	.11	.05	-.04	.36*	-.02	-.12	.20*	.17*

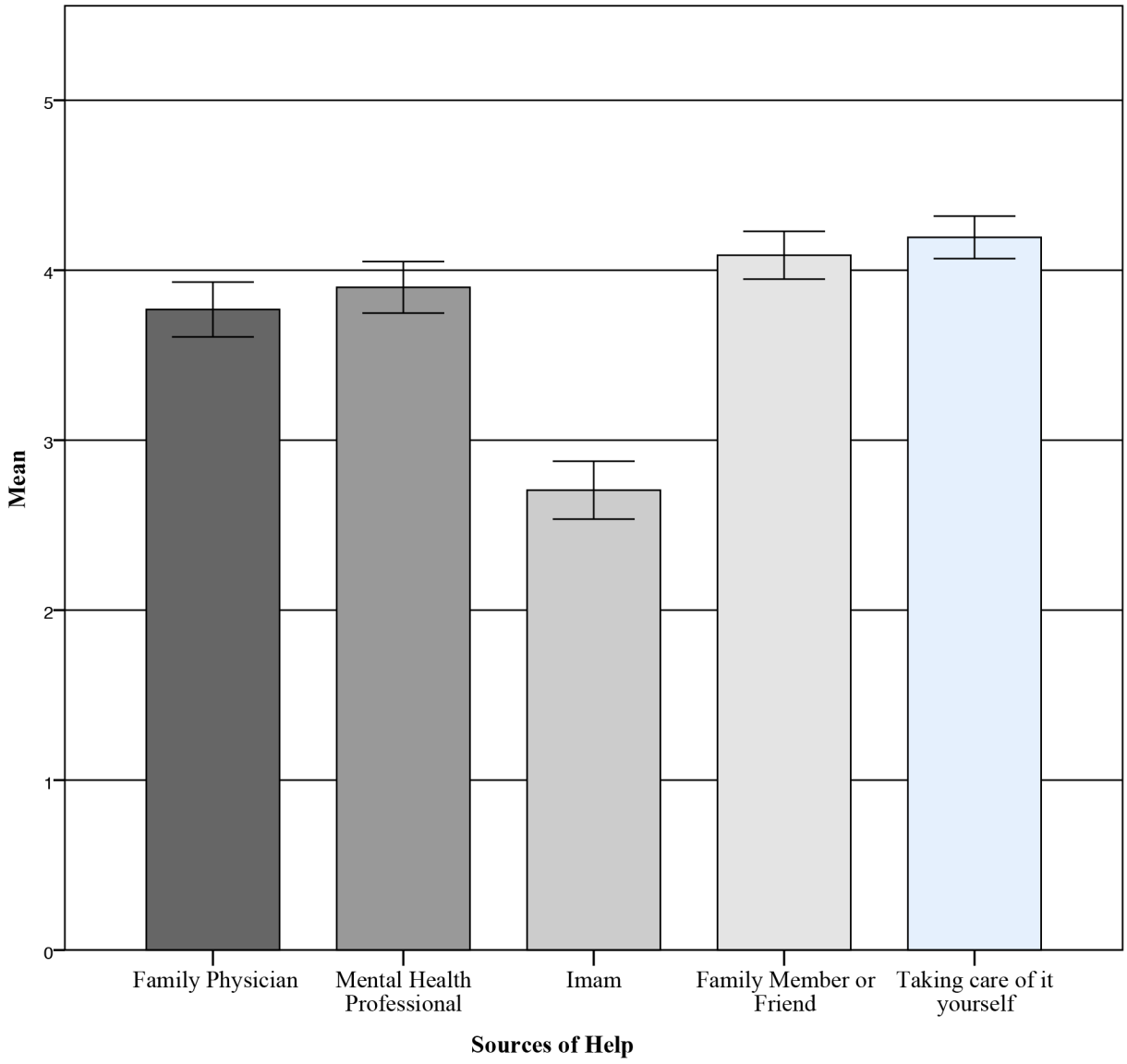
Note.

1. Gender (1 = Male; 2 = Female; other genders not reported)
2. ROI = Religiosity of Islam scale
3. K6 total mean score (0 = no distress; 24 = most distressed)
4. Service Use item reflecting perceived need over the past 12 months (1 = no; 2 = yes)
5. Psychological help-seeking preference (1 = extremely unlikely; 5 = extremely likely)
6. Lifetime Mental Health service use from various providers (1 = no; 2 = yes)

* Indicates significant associations

Figure 1

Canadian Muslims' Mean Preference Scores for Seeking Services for Mental Health Problems from Various Sources



Note. Confidence intervals that do not overlap represent significant differences.

DISCUSSION

The prevalence of severe psychological distress in the current sample was almost double that of the general Canadian population (Caron & Liu, 2010). It is unclear whether these findings are representative of the Canadian Muslim population as a whole. However, the prevalence of distress in this sample may be attributed to several factors, including the large proportion of immigrants. Immigrants to Canada are often educated professionals who take lower-paying jobs due to strict educational equivalency laws, resulting in drastic lifestyle changes following immigration (Ontario Human Rights Commission, 2013; Galarneau & Morissette, 2008). Indeed, Muslims in Canada report that economic and vocational challenges are major problems (EISR, 2016). Additional immigration-related psychosocial factors, such as acculturation (Akram-Pall & Moodley, 2016), as well as Muslim-specific factors such as Islamophobia (Samari et al., 2018), may also contribute to this sample's high prevalence of psychological distress. These findings warrant future in-depth studies of Canadian Muslims' psychological distress.

While 65% of the sample endorsed clinically significant levels of psychological distress, and 60% indicated a perceived need for mental health services in the last year, less than half of participants reported a lifetime history of psychological service use. The discrepancy between the need for, and actual use of, services among this sample of Canadian Muslims is consistent with past research in the general population, where less than half of individuals (43%) who are diagnosed with depression each year seek any mental health services (Sareen et al., 2005). Those who need treatment do not always seek it due to structural (e.g., cost of treatment) and attitudinal (e.g., stigma; Wang et al., 2007) barriers. In this sample specifically, it is possible that additional factors such as Islamophobia (Samari et al., 2018) and cultural mistrust of Western counselling services (Amri & Bemak, 2013) are also significant barriers to treatment.

The correlational findings of the current study speak to other factors related to preferences for informal and formal sources of mental health support. With respect to informal sources, our participants indicated that they would be most likely to deal with psychological problems themselves or by talking to family members or friends. This preference for dealing with mental health problems on one's own is a well-known finding in the help-seeking literature (see, for example, Andrade et al. 2014), and likely reflects both a cultural emphasis on self-reliance and a reasonable expectation to attempt to solve emotional problems on one's own before stepping up to more intensive help-seeking efforts. With respect to those more intensive sources of support, intentions to seek help from general practitioners and mental health professionals were stronger among women and older participants in this study, replicating previous findings in the general population (Mackenzie et al., 2006). Aside from gender and age, the strongest association between intentions to seek services from mental health professionals, general practitioners, and imams was past use of those respective services. These findings likely reflect that previous experience with a service improves a person's attitudes toward it, and consequently improves intentions to seek the service in the future (ten Have et al., 2010). Psychological distress and perceived need for mental health services were weak or non-significant predictors of intentions to seek help from general practitioners or mental health professionals, whereas greater emotional distress and perceived need decreased the likelihood of seeking help from an imam. Instead, the strongest predictor of seeking help from an imam for mental health concerns was religiosity, perhaps because more religious individuals likely have a pre-existing and ongoing relationship with spiritual leaders that would decrease barriers to discussions about mental health.

Findings from this study challenge previous claims that Muslims living in Western countries may be more likely to seek services from religious and spiritual leaders than from mental health professionals (Abu-Ras et al., 2008). Services from an imam were the least preferred treatment method in this sample. It is possible that participants in our sample believe that mental health concerns are punishments from God or indications of weak faith (Weatherhead & Daiches, 2010), and may avoid services from imams due to concerns that they will be perceived as sinful. Although it is possible that these findings are reflective of the high level of education in the sample, given previous findings that highly educated immigrants are more inclined to seek services from mental healthcare professionals than from religious leaders (Gorkin & Othman, 1994), correlational findings suggest that education was not significantly associated with intention to seek support from any source other than friends or family. Future research is needed to explore Muslims' healthcare preferences to further clarify these findings.

There are a few limitations to the current study which must be considered. First, while approximately half of the sample endorsed a lifetime use of psychological services, this does not necessarily indicate these participants' mental healthcare needs are being met. Ethnic minority clients are more likely than White clients to receive lesser quality mental health care (see, for example, Sue et al., 2009). It is therefore possible that some participants from the current sample who accessed psychological services in the past did not receive adequate care or ended treatment prematurely. Second, intentions to seek future services were used as a proxy for actual service use. While intentions are the best predictors of future behaviour (Ajzen & Fishbein, 2005), intentions do not equate to engaging in complex behaviours such as seeking mental health services. Future studies are needed which examine Muslims' actual service utilization and associated psychosocial barriers. Third, this study did not collect data about participants' access to mosques and faith leaders. If participants were unable to access their local mosque, or if they did not have a local mosque with a dedicated imam, their likelihood to seek support from a religious leader may be reduced. Finally, it is unclear if the current sample is representative of Canadian Muslims. Muslims appear hesitant to participate in psychological research, which may contribute to their general underrepresentation in mental health research (Amer & Bagasra, 2013). Additionally, the survey dissemination strategy (i.e., via internet) and the language used may preclude participation from individuals who are not proficient in the use of technology and those who are not fluent in English. Consequently, this sample of well-educated and psychologically minded Canadian Muslims with high prevalence of psychological distress and lifetime history of service use, and generally favourable intentions to seek professional treatment, may diverge from the general Canadian Muslim population. Finally, this study did not collect data on what part of Canada participants were from. Future research is needed which attempts to facilitate broader engagement from the population using multi-lingual surveys and in-person recruitment strategies at local mosques and Islamic community centres, including in different Canadian regions. Future studies should also include exploration of how specific demographic factors (e.g., socioeconomic status, race, etc.) interact with participants' help-seeking intentions.

Findings from this study, which highlight rates of distress and a discrepancy between treatment need and utilization, are among the first to suggest that Canadian Muslims may be an underserved population regarding mental health service utilization. Future research is needed to develop a more nuanced understanding of the mental health needs of Muslims in general, as well as diverse groups of Muslims such as those living in the West. The development of interventions to improve help-seeking among Muslims living in Canada may also

be warranted. For instance, preliminary research investigating a psychoeducational addictions program that was spiritually adapted for Canadian Muslims appears promising in improving treatment seeking (Hassan et al., 2021). Moreover, as Muslims in the current sample were likely to endorse previous service use, promoting cultural competence of clinicians working with Muslim clients may be needed to ensure high-quality treatment for this growing proportion of the Canadian population.

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