Addressing Mental Health Issues

Among American Muslims in the Military

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REPORT

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Table of Contents

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Background

THE TRAGIC SHOOTINGS at the Fort Hood Army Base in Texas raised the public's attention toward Muslims serving in the United States Armed Forces. [1] [2] [3] There was much public conjecture about the motives and mental state of Major Nidal Hasan. While mental health services in the military exist and are utilized by many soldiers, one question that emerged after the shootings was if the military provided adequate support services for American Muslims.

Improved mental health among all soldiers yields numerous benefits, including the potential reduction of self- and other-directed harm. This brief will offer policy recommendations intended to improve access to mental health services for American Muslim military personnel in order to properly care for those who may be at a higher risk for emotional distress.

This brief was developed collaboratively by drawing upon the expertise of providers and researchers of mental health and related services to the American Muslim civilian population, as well as of Islamic chaplains *(imams)* and providers with specific experience in delivering such services in the military context. It is intended to advise policymakers, mental health and public health administrators, and senior military officers, all of whom are invested in Muslim officers' mental health, well-being, and high performance in their respective diverse units.

"IN GENERAL, MILITARY PERSONNEL WITH MENTAL ILLNESSES ARE AT AN INCREASED RISK OF VIOLENCE."

Challenges with the Current Policy and Programming

CURRENT MILITARY POLICY for addressing service members' mental health issues includes understanding that mental fitness is an important aspect of overall health and appreciates the various types of stresses and subsequent effects upon officers, including biological and psychosocial issues. Early intervention relies on the commanding officer's ability to identify usual and unusual behavior by a member of his or her unit. The commanding officer may then recommend that the service member receive interventions by one of the military's several mental health professionals. A commanding officer may refer a service member for psychiatric evaluation if he or she believes that the individual is or may become mentally unfit after consultation with a doctoral-level behavioral provider. An exception is made for cases in which the commander determines that an emergent situation (i.e., imminent risk to self or others) has arisen and immediate evaluation is warranted. Significant efforts are made by each branch of the military to develop prevention and early intervention programs, such as:

1] Quarterly unit suicide prevention trainings;

2] Pre- and post-deployment mental health screenings;

3] Training to include combat stress control;

4] Post-deployment health assessment;

5] Post-deployment health reassessment;

6] Unit behavioral health needs assessment; and

7] Annual physical health assessments, which contain mental health evaluation components.

While some mental health professionals in the military find themselves burdened, even heavily burdened, efforts have been made in recent years to increase the number of active duty and civilian behavioral health providers. For instance, the army provides three-year critical skills retention bonuses, repays higher education debt, and is creating more residency training sites and social work master's programs. In addition, the individual may receive counseling support from chaplains.

In general, military personnel with mental illnesses are at an increased risk of violence. The usual assessment of violence risk involves inquiring into the soldier's past history of violence, substance use, access to firearms, history of mental illness, recent losses, sense of hopelessness, lack of support, and conflicts within family or work situations. In a recent study, however, veterans with severe mental illness and violence were found to have associated head injury, post-traumatic stress disorders (PTSDs), substance use, and homelessness. [4]

Specifically asking about intent and identifying any particular victim can assess dangerousness. Potentially violent individuals may be more likely to disclose information to clinicians with whom they have a trusting relationship, in which case the clinician may engage Tarasoff II (the duties to warn and to protect). Although predicting violence remains difficult, early intervention can surely help reduce the consequences of violence. Increasing data demonstrates that domestic violence is a growing concern among military personnel. [5] Health professionals are also at an increased risk for mental illness and compassion fatigue.

In spite of the extensive behavioral health and primary care services afforded to veterans, as well as systematic screening upon return from the wars, most soldiers do not seek formal mental health services. This is due partly to access issues, stigma, command climate, operation tempo, a military culture that equates help-seeking behavior with weakness, and the perception that seeking such assistance will, ipso facto, have negative career implications. The military has made sincere and concerted efforts to address all of these concerns, and yet the suicide rate among military service members continues to be unacceptable.

Barriers to Mental Health Treatment

WE SUGGEST THAT there may be barriers between policy and actual practice, barriers that need to be addressed. The challenges to the policy may come from an under-appreciation of the religious and cultural backgrounds that help establish or become a barrier between the provider and the recipient of care. Adequately identifying sensitive behavioral health issues requires a trusting relationship, one separated from the possibilities of perceived coercion or mistrust. Only then can the individual who needs help be adequately assessed and become likely to seek and to engage in culturally appropriate mental health services.

As detailed by the Center for American Progress report *"The Hidden Toll of the War in Iraq Mental Health and the Military,"* some Americans, regardless of their ethnic and religious backgrounds, have endured significant hardship and emotional distress while serving in Iraq and Afghanistan. Several large epidemiologic studies have demonstrated the increased incidence of depression, PTSDs, suicide, alcohol abuse and dependence in American veterans of these wars. In general, many soldiers feel internally conflicted about engaging in warfare and facing the possibility of harming or even killing others. [6] More direct combat leads to higher levels of stress and internal conflict. [7] This internal conflict can be heightened when soldiers identify with the opposing side (i.e., religion, ethnicity, etc.). There are no unbiased assessment tools to analyze one's general internal conflict with war or internal conflict toward fighting people with whom soldiers may have an intrinsic connection.

According to the RAND Corporation, individuals may be discouraged from seeking mental health services because they believe that doing so will have negative career repercussions. It is well established that minorities do not receive the same level of health care as do their white counterparts. For both of these reasons, there may be fewer options for Muslim service members as compared to their colleagues. Therefore the current policy may need to be adjusted for the general population, and certainly for minority populations, so that it may contain a strategy designed to assure that actual services are provided and received.

Mental Health Issues of American Muslim Military Personnel

NO PUBLISHED STUDIES specifically address the mental health needs of American Muslim military personnel. The extensive literature on those who return from Afghanistan and Iraq, however, as well as the emerging literature on the American Muslim civilian population, may be extrapolated to acquire a better understanding of the challenges facing this military subgroup.

According to Gallup, American Muslims are a largely middle to upper income population, highly educated, and upwardly mobile. This diverse population also includes multi-generational households; single female-headed households; indigenous Muslims; refugees; new immigrants; newly converted Muslims; people of all ethnic backgrounds; and Muslims who have experienced trauma, torture, and abuse in their homelands and wrongful incarceration and/or discrimination within their new homeland (viz., the United States) based on their ethnic, religious, or racial backgrounds. [8] [9]

As the American Muslim community has grown, it has experienced social problems common to most growing minority communities: pockets of poverty, underemployment, and unemployment; a lack of adequate health insurance; poor intergenerational communication; a rising divorce rate; family violence; and limited community support.

Although no large-scale community-based studies have systematically delineated the differential rates and prevalence of the major mental illnesses among Muslims as a group, a recent study did find evidence for clinically significant levels of depression among a sample of Muslims from across the country. [10] This study suggests that many more American Muslims may be suffering from high levels of depressive symptoms than is appreciated by providers or by the individuals themselves.

Other studies have shown that there may be some differences in how mental health issues are presented among Muslim Americans. For example, some Muslims with issues of depression have a tendency to experience physical health problems rather than verbalizing mental health complaints. Muslims with substance abuse problems may be ashamed to seek help because Islam prohibits such addictive substances. Muslims tend to be very private when dealing with their family and mental health problems within their communities, and thus most practicing Muslims are reluctant to seek the services of secular and non-Muslim providers. For example, women experiencing domestic violence issues may feel uncomfortable about involving non-Muslim providers in situations if they feel their religious and cultural context will not be respected.

Challenges Faced by Muslims after 9/11

IN THE AFTERMATH OF 9/11, many Muslim Americans became more involved in their communities and more engaged in civic and nonprofit activities with their non-Muslim neighbors. As a result of the misdirected anger following this tragedy, however, many other Muslim Americans expressed a pervading sense of insecurity, vulnerability, and lack of safety issues as immediate reactions and responses to the trauma, thereby reflecting their psychosocial state and the effects of the threat of hate crimes. [11] [12] Those who experience this insecurity have become increasingly isolated from the larger community and withdrawn from their social groups; moreover, their ability to cope with trauma through a communal grieving process has been impaired. [13] [14] [15] [16] Anti-Islamic sentiments, prejudicial biases, and faulty assumptions among popular media outlets and many non-Muslim mental health professionals who serve this community further increase the distance between Muslims and care providers. [17]

As a psychologically stressful and traumatic event, 9/11 resulted in a greater need for therapeutic interventions. Yet Muslims continue to experience discrimination, feel the various pressures related to their lives in this country as a systematically targeted population, [18] and express a fear of how mental health professionals and social workers perceive them. They are also intimidated by the power these service providers wield in their lives and are thus less likely to seek care. [19] Unaddressed traumatic events are likely to increase the rates of PTSDs and related problems. Physical abuse, hate crimes, and discrimination based on one's ethnic and cultural identity as a Middle Eastern or South Asian [20] strongly suggest the need for outreach services. [21] Muslims may seek services from respected elder family members or Islamic clergy (such as Islamic chaplains or *imams*) because they are less likely to be stigmatized by their own or the larger community and may feel that religious teachings will be incorporated into the interventions.

Acting as de facto first-line mental health providers, clergy members often see people in the earliest stages of distress and possible mental decline, both of which may masquerade as a social issue or, in the case of people with fringe views, as religious or political extremism. There is a huge disparity between the number of qualified Islamic chaplains and the number of American Muslims who seek their help. This problem is magnified by the lack of professional training found among most imams in the United States. Although they may want to address their congregants' mental health needs, they have little actual connection with professionals and make relatively few referrals to providers in their communities. [22]

One of the most significant needs facing American Muslims is that of trained, culturally and spiritually sensitive mental health professionals and counselors. Most secular and non-Muslim providers are unfamiliar with this community and have not received the education and training needed to provide culturally competent services. Islamic chaplains are unique in that they can provide outreach and liaison services to those less likely to seek mental health services; moreover, they are trained to appreciate the community's social, psychological, and institutional issues while understanding and educating others about mental health issues and appropriate interventions within that particular context.

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Islamic Chaplains Addressing the Mental Health Issues of Muslim Military Service Members

CHAPLAINS HAVE a privileged role in providing counseling and pastoral services to military personnel. A military chaplain can serve as a direct care provider, as a referrer and liaison to other providers, or as a mediator between the individual seeking help and an institution or commanding officer. During times of distress, chaplains can offer condolences and emotional support, as well as perform rituals and religious rites to alleviate some emotional distress and provide hope for the bereaved, as individuals or as a group. Ideally, the presence of a Muslim chaplain could serve as an important resource to any Muslim who may have questions or problems concerning religious, spiritual, or moral issues.

There are only eleven Islamic chaplains in the entire United States Armed Forces, yet thousands of Muslim service personnel are assigned in various locations throughout the world. Chaplains of any background may act as liaisons to finding Muslim mental health providers for active duty members. But access to such providers is limited by the lack of knowledge of their existence or their unavailability in the locales where military bases tend to be established. Even when found, the repeated shifting of personnel makes it difficult for the military member to establish and form a therapeutic relationship with his or her mental health provider. Military chaplains and spiritual leaders can be involved in the violence-risk evaluation of service members and veterans, especially those suffering from mental illness and traumatic brain injury.

Like all veterans who receive services from Veterans Affairs (VA) hospitals, Muslim veterans at most major VA facilities should have access to providers in the Psychology, Psychiatry, Social Work, and Pastoral Care departments (through the VA Chaplain Service). As of May 2009, only five Muslims were listed in the VA Chaplain Service's national directory. Currently, the most favorable alternative for a Muslim veteran seeking mental health services at the VA would be to encounter clinicians who have received cultural-competence training. Through a series of didactic lectures, role playing, and clinical examples, clinicians of any background can take steps toward providing more culturally appropriate care. For example, while working with observant Muslims they may become more open to understanding how the patient's religious worldview can be incorporated into an effective treatment plan.

In both the military and civilian contexts, Islamic chaplains often provide the necessary link between the religious and mental health needs of those seeking services and those providing them to Muslims. In the military context, Islamic chaplains are frequently an effective avenue from which Muslims can receive and accept reliable mental health services, because a trusting, therapeutic relationship can be established with an individual who appreciates the context of the institutional problems within the framework of one's religious and spiritual identity.

Conclusion

ADDRESSING MENTAL HEALTH issues among Muslim military personnel is an important strategy in maintaining a well-functioning diverse group of individuals who can perform well in times of physical, emotional, and cultural challenges, as is the case when at war with predominantly Muslim countries. Furthermore, erratic behavior can be prevented as warning signs and risk factors are often present well before any serious disruptive and dangerous behavior occurs. The therapeutic relationship requires that the military member feel comfortable with his or her mental health provider and that the provider is trained to receive that information in confidence and in context.

In civilian settings, Muslims have tended to seek services primarily from religious and spiritual advisors, as well as from social service, as opposed to mental health, providers. This may be due to the stigma against mental illness, a fear of reprisal, or a lack of appreciation of having a mental health issue.

In the military context, where available, Muslim military personnel with emotional or other psychological distress will usually first seek help from Islamic chaplains. The relative stigma against seeking mental health services for individuals of any background, and the particular stress and limitations placed upon Muslim personnel fighting in predominantly Muslim countries, places a greater emphasis on the need to establish a stronger Islamic chaplain contingency in the military. Additionally, training non-Muslim mental health providers to be sensitive to the potential religious, social, and cultural experiences of Muslim service members can improve immediate access to mental health professionals.

While Muslim civilians and military members, like other groups, have experienced phenomenal challenges in coping with post-9/11 stress, poverty, discrimination, domestic violence, and marital and family disruption, they have also been especially resilient. When culturally competent and spiritually relevant professional services are available, support networks are in place, and they have strong yet balanced religious practice and spiritual ties, Muslims tend to thrive and make significant contributions to society.

We hope that this brief will help mental health professional military personnel and administrators understand which mediator stressors have an impact on military personnel in general and on Muslim Americans' mental health and why, and to learn how to better assist them in coping with the effects of psychological trauma. In addition, it is our hope that this brief will promote cultural understanding between a misunderstood group and society at large and help to foster a sense of mutual respect and sensitivity.

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Recommendations

1 ONE:

Increase access to care within the military. This should include an expanded Islamic military chaplaincy training program to ensure that services are available for as many Muslim military personnel as possible, especially in regions with relatively larger Muslim populations. Additionally, ecumenical chaplains and mental health professionals should be trained and made available to provide culturally appropriate services to American Muslims. Military administrators should encourage their staff to participate in cultural-competency training, which is perhaps the most common institutional method among healthcare professionals for overcoming prejudice and unease with difference.

Furthermore, as part of their training and core competencies all chaplains should be able to screen for mental illness, identify high-risk military service people, and refer cases to the appropriate mental health professionals.

2 TWO:

Expand access to external (viz., non-military) care by creating a directory of multidisciplinary direct service providers. Although military personnel are expected to use VA services when not on active duty, there are cases where civilian-military service interfaces may be more appropriate. Further considerations should be made to improve models of access to direct service providers outside of the military setting for those service members who do not have adequate access to appropriate providers within the existing military mental health service systems.

3 THREE:

Military officials should continue to protect the religious rights of all military personnel. While it will be important to appropriately screen new recruits, active duty, and veteran military personnel for mental illness, emotional distress, and risk of violence, the focus should remain on objective universal measures of risk conducted by culturally competent providers. Creating or using invalidated and inappropriate screening tools to exclusively profile Muslim military personnel should be avoided.

4 FOUR:

Commission a dedicated taskforce to assess the mental health needs and programming services of the American Muslim military community. This taskforce should consist of mental health professional experts on the community's mental health needs. Experts should include, but may not be limited to, psychiatrists, psychologists, social workers, chaplains, *imams*, and community mental health workers.

5 FIVE:

Any immediate shortages of personnel needed to improve the spiritual resiliency of Muslim soldiers should be addressed through civilian contracts. In order to improve their spiritual resiliency and spiritual fitness, religious support is a must; when the mission allows, it should be a primary consideration throughout their career. [20] There is a shortage of active duty *imams*, even though several large military installations have high concentrations of Muslim soldiers (i.e., Fort Huachuca, AZ; Fort Bragg, NC; and Fort Hood, TX). *Imams* hired from the civilian population could augment the garrison chaplain's religious support program.

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