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# PIONEERING AN INNOVATIVE INTERVENTION TO REDUCE MENTAL HEALTH RELATED STIGMA IN MUSLIM COMMUNITIES: A PROTOCOL

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## SUMMARY

*Despite the prevalence of mental health related stigma in Muslim communities, there are only a limited number of intervention studies reported in the literature. Digital interventions (i.e., YouTube clips, videos) are relatively cheap, highly accessible and easily disseminated and are increasingly being used to improve mental health literacy and reduce mental health related stigma. However, as far as the authors are aware, there are no stigma reduction programmes targeting Muslim communities that leverage digital interventions reported in the literature. This paper outlines a protocol for a digital intervention to challenge mental health related stigma in Muslim communities. The proposed intervention will be a 5 to 10-minute YouTube clip/video the active ingredients of which will be: [1] an interview with a Muslim expert by lived/living experience, [2] an Imam (Muslim faith leader) and [3] a psychiatrist. We will recruit members of Muslim communities living in Muslim minority countries in the Global North (United Kingdom, Unites States of America, Canada, Australia and New Zealand) to participate in the study (inclusion criteria: adults aged 18 years and over, Muslim background). The study will be comprised of two groups: an active group that will be exposed to the Muslim faith appropriate digital intervention and a control group that will be exposed to a digital intervention that is not Muslim faith appropriate. We will administer validated psychometric stigma scales on participants in both groups before and after exposure to the interventions. We hypothesize that viewing an anti-stigma clip/video that is Islamic faith appropriate will be associated with greater reductions in mental health related stigma in members of Muslim communities compared to viewing an anti-stigma clip/video that is not Islamic faith appropriate.*

**Key words:** *stigma - mental health - digital interventions - Muslim community*

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## INTRODUCTION

In their review on mental health related stigma in the Muslim community published in 2012 in the Journal of Muslim Mental Health, Ciftci et al. reported that they, *'Could not find any existing anti-stigma intervention evaluations or descriptions specifically targeting Muslim individuals*' (Ciftci et al. 2013). Since then, Hankir et al. conducted three intervention studies challenging mental health related stigma in the Muslim community (Hankir et al. 2017a,b, 2019). These pilot studies were, however, fraught with limitations (i.e., no control group, small sample sizes, no follow-up data etc.) The findings, nonetheless, can be used to help inform the design, development and delivery of an innovative intervention to reduce mental health related stigma in the Muslim community (a description of the intervention and its constituent ingredients/components is provided below).

Altalib et al. published a paper in 2019 entitled, *'Mapping global Muslim mental health research: analysis of trends in the English literature from 2000 to 2015'* (Altalib et al. 2019). The authors conducted an Ovid search to identify articles written in English from 2000 to 2015 that had the terms 'Islam' and/or 'Muslim' in the abstract as well as research conducted in Muslim-majority countries and among Muslim minorities in the rest of the world. Of the 2652 articles on Muslim mental health that they identified, 157 were categorized as stigma/attitudinal (Altalib et al. 2019). No further description, however, was provided and it was not documented if any intervention studies were included. A further limitation was that the study did not include literature on Muslim mental health published after 2015.

Our proposed intervention will primarily be aimed at Muslim university students based in Muslim minority English speaking countries in the Global North (UK, USA, Canada, NZ and Australia). The reasons for this are as follows:

***University life is a challenging period for Muslim students…***

- University is a liminal and transitional stage of life which can render a student, irrespective of their faith background, more vulnerable to developing mental health problems (Bolton & Hubble 2020).

- Muslim students are second and third generation immigrants and this increases their risk of developing mental health problems. They are also prone to experiencing an identity crisis which in and of itself is associated with emotional turmoil (Hankir et al. 2015.
- Muslims who enrol in university are often intimately exposed to 'Western culture' for the first time in their lives i.e., they will move out of their family homes and meet other non-Muslim students in halls of residence who consume alcohol and take illicit substances, have pre-marital relationships and who 'go out clubbing', all 'haram' (prohibited) in Islam. Both resisting temptation and the remorse they often experience if they succumb to it can precipitate psychological distress and shame (Hankir et al. 2015).

Our plan is to develop a digital intervention that will improve mental health literacy and reduce mental health related stigma in the Muslim community. The intervention will be 'manualised' so that the intervention can be reproducible. This will help to improve fidelity and ensure faithful delivery and evaluation of the intervention outside of our study.

We will make allowance for variability so that the intervention can be adapted to local circumstances i.e., in Muslim majority countries such as Qatar, Pakistan and Malaysia.

As described above, as far as we are aware there are only three intervention studies challenging mental health related stigma in the Muslim community published in the literature. Below is a brief description of the studies and the ingredients of the intervention that was delivered:

The Federation of Student Islamic Societies (FOSIS) consulted AH for advice on how to design, develop and deliver three Muslim mental health conferences in Scotland, Ireland, and England (Glasgow (Hankir et al. 2019), Dublin (Hankir et al. 2017a) and Birmingham (Hankir et al. 2017b) studies respectively). The ingredients of the conferences were informed by the results of a systematic review and meta-analysis on challenging the public stigma of mental illness which revealed that contact was better than education at reducing stigma for adults (Corrigan et al. 2012). We therefore included a Muslim expert by experience, a Muslim psychiatrist and an Imam for the FOSIS Dublin and Birmingham events, however, for the FOSIS Glasgow event we only had a Muslim mental health professional and Imam (this is because we were unable to find a Muslim expert by experience for this event). Each event lasted one-day in duration. We administered validated psychometric stigma scales on participants who attended all three conferences (RIBS, CAMI, MAKS). The FOSIS Dublin (Hankir et al. 2017) and FOSIS Birmingham (Hankir et al. 2017b) events were both associated with statistically significant reductions in stigma whereas there were no statistically significant reductions in stigma in the FOSIS Glasgow study (Hankir et al. 2019). We hypothesised that these results supported the 'power of contact' theory i.e., that social contact with a person who recovered from a mental health condition is associated with reductions in mental health related stigma (Hankir et al. 2019). Although these studies were fraught with limitations, the findings could be used to help inform the design, development, and delivery of future Muslim mental health conferences (Hankir et al. 2019). They also reinforce the notion that experts by experience must operate at the vanguard of anti-stigma campaigns (Corrigan et al. 2012).

In a post-COVID-19 world, we anticipate that events and conferences will continue to be hosted online for the foreseeable future (see below). For our study to be feasible, our plan is to develop a digital intervention (i.e., a YouTube clip) that people can access remotely. Janoušková et al. (2017) conducted a systematic review to determine if video interventions were associated with reductions in mental health related stigma in young people between 13 and 25 years. The results revealed that video interventions led to improvements in stigmatising attitudes and that video was found to be more effective than other interventions, such as classical face-to-face educational sessions (Janoušková et al. 2017). The results of two of the studies in the review showed that social contact delivered via video achieved similar de-stigmatization effect to that delivered via a live intervention (Janoušková et al. 2017). The authors concluded that the findings suggest that video is a promising de-stigmatization tool among young people (Janoušková et al. 2017).

Odukoya conducted a study on a complex e-intervention that focused on an integrative approach of education and indirect contact through film as a tool to combat stigma towards people with intellectual disabilities in Nigeria (Odukoya 2017). The e-intervention was faith and culture appropriate since it included interviews with a Christian faith leader and a psychiatrist who both spoke about the explanatory models that many Nigerians formulate for mental illness (i.e., the attribution of psychological, behavioural, and perceptual disturbances to supernatural causes) (Odukoya 2017).

A total of 571 participants were randomly allocated to watch either the intervention or control film. Socio-demographic information and process variables (appropriateness, acceptability of the intervention and barriers and enablers to implementation of the study) were also collected. The results indicated that the use of an integrated approach was found to have a small to medium size positive effect on all dimensions of attitudes except on Knowledge of Causes and that these effects were maintained at follow-up (Odukoya, 2017). Since many Muslims attribute mental illness to supernatural causes, the ingredients of this complex e-intervention can be used to inform the design of our intervention challenging mental health related stigma in the Muslim community.

The intervention would be comprised of the following active ingredients:

- An interview with a Muslim expert by lived/living experience;
- An interview with an expert in mental health (i.e., consultant psychiatrist);
- An interview with an expert in Islamic sciences (i.e., a Muslim faith leader/Imam).

Each interview will be approximately 2 to 3 minutes in duration so that the total duration of the intervention does not exceed 10 minutes.

***Muslim expert***

The interview with the Muslim expert by experience will trace his/her recovery journey and the tools that he/she used. He/she will emphasise on the importance of seeking help from a psychiatrist and that effective treatment is available (i.e., psychological and/or psychopharmacological). His/her account will be faith and culturally appropriate and acknowledge the importance of seeking help from an Imam and/or Muslim faith healer ('*Raqi*'). The expert by experience will also discuss the adverse effects of Islamophobia on his/her mental health and how receiving psychological therapy for this was helpful.

***Imam***

The interview with the Imam would begin with a brief description of how the first psychiatric hospitals in the world were constructed in Baghdad during the Islamic Golden Age and that a biopsychosocial model of mental illness was adopted. The Imam would emphasise that mental illness was and remains a medical illness that requires medical treatment. The imam will briefly discuss that having mental illness does not mean that you have weak faith as even the prophet Mohammed (PBUH) experienced emotional turmoil and psychological distress. The Imam will recognise how beneficial prayer and reading Quran are for mental health however will emphasise on the importance of seeking help from a mental healthcare professional.

***Psychiatrist***

The Muslim psychiatrist will discuss the risk factors that render Muslim students vulnerable to developing mental illness. The psychiatrist will also discuss ways that Muslim students can develop mental health resilience. The psychiatrist will recognise and talk about the explanatory models that many Muslims formulate for mental illness (i.e., they usually attribute psychological, behavioural and perceptual disturbances to 'Jinn possession' and/or being cursed by the 'evil eye of envy'), however, he/she will emphasise on the importance of seeking help from a mental health professional for assessment and treatment. The psychiatrist will also emphasize that effective treatment is available and that 'recovery is a reality for the many, not the few' thus planting the seeds of hope into the hearts and minds of Muslims with mental illness who often succumb to despair.

There have been heightened levels of Islamophobia in the UK and elsewhere in the Global North. Jonas Kunst and colleagues developed and validated the Perceived Islamophobia Scale (PIS) which revealed an association between Islamophobia and psychological distress in a sample of 1400 Muslims from the UK, France and Germany (Kunst et al. 2013). With the rise of populism and isolationism, the ongoing hostile attitudes towards refugees (many of whom are Muslim) and Brexit, Islamophobia is expected to increase even further.

A 2020 study published in the British Journal of Psychiatry revealed high levels of mental health stigma in Pakistan, a Muslim majority country (Husain et al. 2020). It is hypothesised the traditional beliefs about causation of mental illness in Muslim majority countries (which are mostly low- and middle-income countries) are more deeply entrenched (Husain et al. 2020). The intervention may need to intensify (i.e., participants may need to receive 'higher dosages') to reflect how deeply entrenched attitudes are.

The COVID-19 pandemic has resulted in the closure of many mosques and events and conferences are now being held online. Our intervention will be delivered in a post COVID-19 world and it is hypothesised that events and conferences will continue to be held online for the foreseeable future. A previous online event that AH was invited to speak at (the 2020 Royal College of Psychiatrists National Medical Student Conference) was attended by over 400 medical students throughout the UK and Ireland. The evaluation for the event also had a high response rate. Such an event can serve as a model to refer to for the design and evaluation of our digital intervention.

We will identify and approach appropriate users for all stages of the development, process and outcome analysis of our intervention to increase the chance of producing implementable data. Appropriate users include, experts in Muslim mental health (i.e., Professor Rania Awaad who is the Director of the Muslim Mental Health and Islamic Psychology Lab at Stanford University. Professor Awaad presented her research findings on Muslim mental health to Barack Obama at the White House. AH has co-edited a textbook with Professor Awaad on Islamophobia and psychiatry (Moffic et al. 2018) and is in close communication with her. Furthermore, AH is also in close communication with Dr Ghazala Mir at Leeds University who pioneered an innovative form of psychological therapy that incorporates Islamic principles in the treatment of depressive illness in Muslims which was associated with positive outcomes (Mir et al. 2015); Muslim experts by lived experience and Imams who have an interest in Muslim mental health are other users/stakeholders, we will consult. We would also carry out qualitative research with the users and stakeholders to obtain important insights which would inform and guide the development and evaluation of the intervention. The broad range of views that are elicited from our users can then be canvassed and systematically incorporated into the design of our intervention as well as the design of our evaluation.

We will also consult with the users and stakeholders to obtain their advice in relation to the feasibility and acceptability of the study.

We will abide by the highest standards of ethical approval for our study and obtain IRB approval from King's College London. The autonomy of Muslims invited to participate in the study will be respected and we will obtain informed written consent. Participants are free to leave the study at any point. Our study will recruit Muslim members from the general public and will not include people with severe mental illnesses receiving treatment in inpatient settings. The intervention is psycho-educational and is unlikely to have any adverse effects. All data will be anonymised, stored in a secure database, and confidentiality will be respected at all times.

## Timeline

***0 – 6 months:***

Refine protocol. Obtain ethical approval to conduct qualitative research with appropriate users/stakeholders (described above). Carry out interviews with them and obtain their views on the design of the intervention and evaluation. Carry out systematic review of mental health stigma in the Muslim community and be guided/informed by the findings.

***6 – 9 months:***

Create the intervention that will be guided/informed by the information gleaned by users/stakeholders and the results of the systematic review. We will conduct interviews with an expert by experience, expert in Islamic sciences (Imam) and expert in Mental health (i.e., Muslim psychiatrist). We will design the manual for the intervention so that it can be reproducible.

***9 – 21 months:***

Recruit participants and collect and analyse data. Most, if not all, universities in the UK and Ireland have an Islamic Society ('ISoc'). University ISocs often organize events on Muslim mental health which are popular among members and have a high number of people attending (previous events had, on average, between 50 to 100 attendees). The umbrella organization for university ISocs is the Federation of Student Islamic Societies (FOSIS). FOSIS have also organized multiple Muslim mental health conferences which are also popular and highly attended (previous FOSIS Muslim mental health conferences attracted between 100 to 200 attendees).

Our plan is to work closely with University ISocs in the UK and Ireland and FOSIS. We will invite participants to complete outcome measures before and immediately after exposure to the intervention. We will also invite participants to complete outcome measure 4-week after exposure to the intervention.

Participants would be invited to access a link to a digital version of the forms. We would also collect the email addresses of the participants so that we could send the forms to them at 4-week follow-up. Necessary measures will be put into place to safely and securely store all data and responses collected. We will conduct a sample size calculation by referring to previous studies that reported the development and evaluation of interventions that are appropriate to faith and culture and that aimed to reduce mental health stigma. We anticipate that if we organize 5 online events with an average attendance of 200 students, we will recruit 5000 students if we have a 50% response rate.

Outcome measures: Validated psychometric stigma scales i.e., RIBS, CAMI, MAKS to be administered at baseline before exposure to the intervention, immediately after exposure to the intervention and at 4-week follow-up.

***21 – 24 months:***

Write up including results of systematic review, data analysis, results, discussion, conclusion, and future directions.

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***Contribution of individual authors:***

Ahmed Hankir conceived the idea for the protocol, conducted the literature review and wrote the entire manuscript.

Melissa Abi Rached revised the manuscript.

Rashid Zaman was the senior supervisor and carried out further revision.

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