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The Role of Muslim Religious Leaders in Mental Health: A Community-Based Participatory Research Study in the San Francisco Bay Area

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Abstract
Muslim religious leaders provide guidance to their communities on social and spiritual aspects of life. Previous studies suggest that religious leaders (*imams*) may also offer counseling and mental health support for Muslims. Research has not investigated the extent to which Muslims rely on religious leaders to fulfill this role. This study explores the perceptions of Muslims in the San Francisco Bay Area, California, regarding the role of religious leaders in mental health care. The study utilizes a community based participatory research approach. A total of 40 participants across four demographic groups (male community members, female community members, young adult community members, and religious leaders) were recruited to participate in focus group discussions. Participants were given six case scenarios illustrating various mental health problems and asked to share their thoughts regarding the role of religious leaders in the management of each case. Focus groups were audio recorded, transcribed, and analyzed using thematic analysis. The themes included participants' expectations of religious leaders' qualifications and limitations as well as the perceived distinction between a religious leader and a mental health professional. The findings of this study provide insights into Muslims' perceptions of the roles that religious leaders play in mental health.

Keywords Religious leaders · Muslim mental health · Community-based participatory research

Introduction

Research has consistently demonstrated that the underutilization of mental health care services is more pronounced among racial/ethnic and religious minority groups, including Muslim Americans (S. Ali et al., 2022; Awaad et al., 2022; Chang et al., 2013; Padela & Curlin, 2013; Villatoro et al., 2014). As the scientific community continues to research and develop effective clinical interventions aimed at addressing this growing need, barriers to care that are unique to these underserved communities must also be addressed. Islam is one of the fastest-growing religions in the world, and the global

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Muslim population is estimated to reach 2.2 billion by 2030 (Grim & Hsu, 2011). Therefore, research aimed at addressing mental health interventions and clinical practice in the United States will impact a patient population composed of an increasing percentage of Muslim Americans, one that continues to underutilize mental health services for reasons not yet fully understood (Aloud & Rathur, 2009).

Many Muslim Americans have described difficulties adjusting to social and cultural norms, and researchers have repeatedly demonstrated the negative psychosocial impact of the socioeconomic and political marginalization of and religious and racial discrimination against Muslim Americans (Basit & Hamid, 2010; Goforth et al., 2014; Lowe et al., 2018; Ward et al., 2018). Despite these significant mental health concerns, some research suggests that Muslims living in the United States are still less likely to seek professional support (Amri & Bemak, 2013; Basit & Hamid, 2010; Khan, 2018). While this may be due to multiple factors, including mistrust of Western counseling services, beliefs that their problems do not warrant treatment, and the limited availability of culturally sensitive therapy (Abu-Ras et al., 2008; O. Ali et al., 2005; Weatherhead & Daiches, 2010), research investigating the full scope of help-seeking preferences by Muslim Americans is sparse.

Muslim Americans usually seek the guidance of religious leaders (imams) in many aspects of everyday life with the goal of ensuring that they maintain adherence to religious commandments and law in their daily practice, mental health care being no exception (Ali, 2016). In 2009, researchers Aloud and Rathur published the help-seeking pathways of Arab-Muslims model, which proposed that Muslim Americans, upon recognizing that they are experiencing mental health or psychological problems, tend to go through three identifiable stages: (1) problem awareness and recognition, (2) the decision to seek help, and (3) services selection (Aloud & Rathur, 2009). The model theorized that Muslim Americans encounter a wide range of obstacles when passing through these theoretical stages that may prevent them from seeking appropriate help. Furthermore, social stigma surrounding mental health within the Muslim community has been repeatedly implicated in existing research aimed at addressing Muslims' perceptions of mental health (Alhomaizi et al., 2018; Aloud & Rathur, 2009; Khan et al., 2019) and likely contributes to the underutilization of formal mental health care services by Muslims across all three proposed stages. It is through the identification of key players at these pivotal turning points in the help-seeking pathway of Muslim Americans that we may begin addressing these invisible barriers. This is further supported by research that has suggested that Muslims are more likely to turn to their religious leaders (imams) regarding issues related to mental health (Abu-Ras et al., 2008; Al-Darmaki, 2003; Aloud & Rathur, 2009; Sabry & Vohra, 2013). In a study investigating the role of New York City imams following 9/11, findings suggested that imams were expected by congregants to provide counseling in areas beyond the scope of their religious training (Abu-Ras et al., 2008). Similar studies suggested that Muslims in the United States were more likely to seek mental health support from religious leaders than from mental health professionals (O. Ali et al., 2005; Aloud & Rathur, 2009).

Traditionally, the role of an imam includes leading daily communal prayers, delivering sermons during religiously significant events (e.g., holidays, funerals), and providing religious and spiritual guidance to congregants (Padela et al., 2017). Imams may be uniquely positioned to positively impact individuals at various stages of mental health help-seeking, from awareness of existing mental illness to the decision to seek out formal mental health services. However, there has been little expansion regarding community-based perceptions of imams and their role in improving mental health outcomes within Muslim American communities.

Unfortunately, mental health stigma, further compounded by social mistrust, also serves as a barrier to minority engagement in research and continues to hinder research attempts to understand and address Muslim American mental health needs (Amri & Bemak, 2013; Ciftci et al., 2013). In order to effectively meet the needs of this growing population, we propose the utilization of a community-based participatory approach to further elucidate the role of Muslim religious leaders with regard to the mental health of Muslims in America. The current study includes the perceptions of both community members and imams in order to more fully understand the experiences and expectations of Muslim Americans regarding the roles of religious leaders in mental health. Community-based participatory research relies on the involvement and integration of community members most affected by the research topic during various stages of research design and implementation, resulting in the development of prevention programming and interventions that are tailored to each community's specific needs. Through engaging with, rather than disregarding, the religious beliefs and cultural realities of Muslim Americans, we hope to utilize the voices of both community members and imams to characterize their perception of Muslim religious leaders' role relative to mental health broadly and in community members' help-seeking journeys.

Methods

Study design

The data presented in this paper are part of a qualitative study exploring facilitators and barriers to mental health care among Muslims residing in the San Francisco Bay Area of California. The data were collected across four focus group discussions using a community-based participatory research (CBPR) approach, which is a collaborative approach to research in which community members and representative institutions are equitably involved in the research process with the partnering academic research team or university (Holkup et al., 2004).

Recruitment of participants

Using a CBPR approach, the university-research team established a partnership with the Muslim Community Association of Santa Clara, California, one of the largest Islamic centers in the Bay Area. A community advisory board (CAB) of individuals from ethnically diverse groups of Muslims led the efforts on the design and recruitment of the focus groups. Details regarding the establishment of the San Francisco Bay Area Muslim Mental Health CAB are discussed elsewhere (S. Ali et al., 2023; S. Ali & Awaad, 2018). The CAB helped guide the research process to ensure that the study methodology was culturally and spiritually congruent and reflected the needs and voices of the Muslim communities of the Bay Area.

The CAB facilitated the design of a recruitment matrix and aided in determining the inclusion criteria. The inclusion criteria required that participants self-identify as Muslim, be older than 18 years of age, speak English, and reside in the Bay Area for at least 1 year prior to participation. To include diverse religious backgrounds, the recruitment process focused on participants who identified as Muslim regardless of their level of religiosity

or mosque attendance. Using the CAB's social networks, 37 community members and 3 imam participants were recruited and consented to participate in the study.

Four focus groups were conducted: men ($n=10$), women ($n=17$), young adults ($n=10$), and religious leaders ($n=3$). The ages of the young adult group ranged from 18–25 years, and the other community member groups' participants were 26 years old and older. The focus groups were conducted in the Muslim Community Association's building, which was presumably a familiar space for all participants. Each focus group was run by two facilitators from the CAB who were trained in focus group facilitation by the research team. The first three focus groups ran simultaneously and were supervised onsite by the principal investigator. The fourth focus group (the imams) was conducted separately, given challenges due to limited availability and time commitments of the imam participants. Each focus group lasted approximately two hours.

Data collection

Six hypothetical case scenarios of Muslims suffering from a mental illness (see Table 1) were presented to participants in each focus group. The illnesses were not explicitly identified in the scenarios but were created to reflect psychosis (case scenario 1), maladjusted coping (case scenario 2), suicidal ideation (case scenario 3), trauma from sexual abuse (case scenario 4), grief and depression (case scenario 5), and panic attacks (case scenario 6). The scenarios were contextualized in social and religious dilemmas to elicit participants' thoughts regarding both the spiritual and psychological difficulties manifesting in

Table 1 Case scenario summary

Scenario 1	Noah is a university student who has struggled with insomnia and general malaise since beginning college. Recently, he has started to hear voices and see people out of the corner of his eyes that others do not notice. His biological father, according to his family, also showed similar signs. His concerned family took him to the imam to voice their concerns, only to be reassured and told to recite some *dhikr* (religious invocations).
Scenario 2	Adam is a 32-year-old man trying to get married. He is growing cynical with the halal marriage process because his dowry was rejected by the family of a woman he had proposed to. He has resorted to poor coping mechanisms to address his anger, such as drinking and displacing his marriage frustration onto his coworkers, resulting in his having to take time off from work.
Scenario 3	Sarah is a 36-year-old single female who has been trying to get married for 15 years to no avail. She has experienced significant pressure from her family throughout this process. As a result, she has taken off her hijab and decided to get plastic surgery and Botox injections. Unfortunately, she still has not been successful in finding a marriage partner and has resorted to suicidal thinking and thoughts of low self-worth.
Scenario 4	Sophia is a 17-year-old female who was sexually assaulted by her uncle in elementary school. Her family became aware of the abuse but chose not to persecute the uncle. He therefore remained a part of Sophia's childhood. Once she entered high school, she was sexually promiscuous and became pregnant. Her family became overwhelmed with shame.
Scenario 5	Mohammad is a 66-year-old male whose wife has recently died. He was very attached to her, and her loss has been hard on him. As a recent retiree, he tries to fill his days with family dinners, but he is often found to be distant and disorganized.
Scenario 6	Miriam is a 27-year-old female who recently immigrated to the United States with her husband. She has become anxious and isolated because of her challenges: she cannot find a job, is recently pregnant, has a young infant, and has been struggling with her husband's income and language barriers. One day, during prayer, she cannot breathe and notices the room is spinning.

each case scenario. The responses of community members and imam participants to these scenarios were further expanded upon via open-ended questions and a discussion of each case scenario. The questions, and the subsequent discussions, probed participants' beliefs and attitudes, particularly regarding the role of imams in relation to caring for the individuals described in the scenarios. The facilitators asked questions such as What does this person need? Who can help? How can an imam help? and What are the resources necessary to support this person?

Data analysis

Focus groups were audio-recorded and transcribed verbatim by a professional transcription service. Using theoretical frameworks derived from the literature, data were coded using NVIVO 12 software in order to examine the role of different service providers in the mental health care of Muslim Americans. In the context of this paper, only data reflecting the role of religious leaders in the mental health care of Muslim Americans were examined for themes. Major codes generated were discussed by the principal investigator, RA, and the co-investigator, SA, and a framework for analysis was thus developed. All the codes related to the role of religious leaders were collected and further analyzed manually by FH. Analysis of the religious leaders' codes was completed using an open-coded approach in which generated concepts were categorized into themes.

These generated themes were cross-examined by all research team members until a consensus was reached on themes and subthemes that described the different roles of religious leaders as conceptualized by the focus group participants.

Results

The responses reflect the perceptions and expectations of the focus group participants related to the role of religious leaders in responding to mental health-related issues. Participants felt that religious leaders could use their religious knowledge as spiritual teachers to guide Muslim individuals in solving internal or interpersonal problems. In addition, participants felt that, as community leaders, imams could also become liaisons in educating and referring people to needed mental health support. However, participants also highlighted that the roles of religious leaders come with limitations and often unjustified expectations. As such, the participants highlighted the need for clear distinctions regarding what a religious leader can and cannot do as well as the need for training to support religious leaders in becoming avenues of mental health support.

The qualitative analyses of the focus group discussion among community members and religious leaders (imams) identified three major themes, each with subthemes (see Table 2). An analysis of the themes and subthemes is presented below with verbatim quotes from participants.

The religious leader as a religious teacher

Multiple participants highlighted their personally held expectations that religious leaders could provide religious knowledge to help Muslims respond to stressful life events. Participants believed that this religious knowledge, delivered by a religious authority figure, could facilitate for distressed Muslims the acceptance of situations that are precipitating

Table 2 Major themes and subthemes from participant interviews regarding perceptions and expectations of religious leaders' roles in fulfilling community mental health needs

Theme	Subthemes
The religious leader as a religious teacher	Provides spiritual prescriptions
	Provides comfort using parables
	Is a social mediator or facilitator
The religious leader as a mental health support person	Educates the community on misconceptions about mental health problems and religion
	Refers to and advocates seeking mental health resources
Managing expectations of religious leaders	Limitations of current religious leaders
	Training and collaboration with imams in mental health care

psychological pain and/or mediate interpersonal relationship issues. Participants shared that they believed religious leaders could become religious teachers in three ways: by providing spiritual prescriptions or suggested practices based on religious doctrine, by providing comfort using religious parables, and by being social mediators or facilitators who assist with interpersonal issues between family and/or community members.

Provides spiritual prescriptions or suggested practices Several participants noted that a religious leader's role included the provision of information regarding spiritual practices to help a person overcome life hardships. For example, when commenting on case scenario 3 about a woman who was having difficulty getting married, a male participant shared how talking to a religious scholar could help her:

> I think she also can benefit from talking to a scholar to help her understand that going through the normal Islamic route of praying and *dua* [supplication] and that not panning out doesn't mean that Islam and prayer isn't working. It might just be working in a different way than what you think.

In this case, a religious leader is expected to teach a distressed individual about supplication and related theological beliefs about when and how supplication is answered and to help facilitate this Islamic practice of seeking God's (Allah's) guidance and finding solace in times of hardship.

Marriage is considered a highly recommended religious activity in Islam, but it is not an obligation (Alghafli et al., 2014). Due to the emphasis placed on marriage, some families or communities may pressure someone who is not married into marriage, which in case scenario 3 created adverse mental health consequences for the individual. An imam participant shared his response on how to intervene with someone facing significant distress due to their inability to get married and how to fill the role of a spiritual teacher:

> So, this would be a situation where the imam needs to work with her, to help her understand what the Islamic marriage [is], how to go about it—and then, at the end, some people—they're just not going to get married in society. And how is she going to cope with being a member of—because you don't have to be a married person to be a healthy Muslim. So, have her understand how she [can] be a healthy Muslim without being so focused on marriage. And if she's making *dua* [supplication] for it every sin-

> gle day, although *dua* is good, this might be obsession—that she's defining herself, and her Islam, and her identity through a marriage. And I think she needs to go around and, you know, work on her Muslim identity first, and then now approach marriage.

Participants who were imams themselves shared that community members usually sought their support in the form of religious prescriptions for understanding and managing their life hardships. A participant who was an imam described his response if the person in case scenario 3.were to approach a religious leader:

> I think one of the things that this person needs—if he were to approach an imam figure—is just a general reminder of *qadr* [fate] and the pillar of faith; this is the *qadr* of Allah. And not to detract from the trial that he's gone through, and, you know, the weightiness of that, but just also to help remind him in terms of that this is the fate of God; part of our pillar of believing is that we accept the fate of God and the *qadr* of Allah.

Thus, in the context of the above case scenarios, the participants indicated that the religious leader's role was to provide religious information to facilitate the person utilizing faith as a means of managing their situation, ultimately leading to healthy spiritual coping.

Provides comfort using religious parables Participants also shared that religious leaders could similarly provide religious knowledge through parables to connect a person's experience with another human experience in the past, especially religious historical figures such as the prophets and their families and companions. These parables are expected to offer comfort and a connection of solidarity to important figures within the faith as a means of processing mental health challenges. An imam participant described an appropriate course of action for religious leaders in response to case scenario 5 about a man whose wife had died:

> Maybe to console him with some of the stories of the Prophet Muhammad—but also, the other prophets, as well, and their loss[es]. . . . So, that's one of the things to do. And then also, stories from the Sahabah [Prophet Muhammad's companions] and so forth.

In the context of the case scenario above, this participant viewed a religious leader's role as including the use of religious parables, such as stories of the Prophet Muhammad's losses, peace be upon him, as tools to facilitate personal reflection, and, ultimately, emotional consolation.

However, since many religious leaders have not had professional mental health training, religious scriptures also need to be considered in context. A female participant highlighted that religious leaders are in general equipped with the skills to preach and provide religious advice but need to be empathetic in giving advice at the right time:

> But I'm trying to kind of think of what a generic imam might say. Maybe have patience. I mean, kind of your standard [response], "This is a test from God, have patience. Remember the Prophet so-and-so went through worse things than you." And I think that's all nice in theory, but I don't really know how effective it is because we hear that over and over again in Islamic lectures, but we still have so many mental health things that are not being addressed and quoting the life of the Prophet [Muhammad] is only going to help so much.

As evidenced by this quote, participants expressed concerns that seeking support from a religious leader would result in religious advice, which could mistakenly conflate their psychological difficulties with faith-related impediments. If a religious leader is

knowledgeable, they would be able to create the boundaries between telling a prophet's story to ease someone's hardship and playing a crucial role in bridging a person to professional mental health support.

Is a social mediator or facilitator Religious teachings could also be delivered to mediate issues in interpersonal relationships. Participants' perceptions of religious leaders' role as social mediators was a salient subtheme within the theme of religious leaders as religious teachers. Several participants noted their expectations that religious leaders should relay pertinent information about religious regulations and norms to help distressed individuals and their families navigate social contexts contributing to mental health concerns. For instance, a male participant explained in response to case scenario 4, "An imam could support an issue that is really working with the entire family because this girl needs to be connected to a family that is healthy.... So, the imam certainly wants to have longer conversations with the family."

Religious leaders were considered respected individuals who could facilitate difficult conversations that some families could not broach themselves. This skill was seen as particularly useful when combined with advice related to Islamic legal practice. For instance, in the Islamic faith tradition, a legal marriage must include an agreed-upon marital dowry given by the husband to his wife, according to his financial means, the amount of which can sometimes cause conflict within and between families (Waheed, 2009). Consequently, participants felt that navigating social conflict requires arbitration from an individual with comprehensive Islamic knowledge who can help families navigate the conflict by mediating it using appropriate Islamic mandates. For example, a young adult participant, commenting on case scenario 2 suggested "maybe finding an imam or a scholar to sort of help facilitate as an arbitrator between the two families because sometimes from an Islamic perspective keeping such a high dowry is not even appropriate."

The religious leader as a mental health support person

This theme highlights the significant role of religious leaders in responding to the direct mental health needs of their community members. The theme expounds on a religious leader's role in the provision of mental health care and includes subthemes highlighting their responsibilities, as a community leader, to educate the community on misconceptions about mental health problems and religion and to refer and advocate seeking mental health resources.

Educates the community on misconceptions about mental health problems and religion Research has shown a prevalence of supernatural (e.g., jinn possession, the evil eye, black magic) and spiritual (e.g., faith crises, sinfulness) attributions for mental health problems among Muslims (Al-Krenawi & Graham, 2000; Fakhr El-Islam, 2008). These findings were reflected in participants who noted that the role of religious leaders included educating Muslim families on community-held misconceptions about mental health problems and religion. For example, commenting on case scenario 1, a female participant stated:

> I think that what he also needed was an imam who could sort of educate the parents at that moment and just tell him there's nothing wrong with you spiritually and reassure him sort of along the lines of what X was saying—that this isn't a faith issue.

> This isn't that you're not protected from that jinn or something like that—that there [are] mental health things that we need to be aware of and you need to seek the help of a counselor.

The participant indicated that religious leaders could play an important role in distinguishing between the influence of evil spirits and mental health problems. This role could contribute to encouraging community members to seek help from mental health professionals.

While the community has expectations that religious leaders understand the difference between mental health issues and supernatural forces, this education is not yet a common part of the training for religious leaders, as explained by an imam participant:

> I'm studying *fiqh* [Islamic law], that mental issues could be either spiritual or chemical. They could be [caused] by the jinn or by the chemical imbalance, which would require medication. . . . It helped me in understanding that when I was faced with the question of, do we go to professionals; do we do medication, say, yeah, of course; there's no harm in going to that. But I don't think a lot of people—in fact, I know a lot of people in their Islamic training—they don't get that. They think everything can be solved by just reading Quran and *dua*.

This imam participant shared that religious leaders do not receive adequate training in distinguishing between spiritual forces and mental health needs. This would be a possible barrier to imams educating the community on misconceptions about mental health problems. Religious leaders who have received adequate training in mental health would be able to clarify the myths and stigma around mental illness in the community.

Refers to and advocates seeking mental health resources This subtheme highlights participants' opinions on the role of religious leaders in encouraging mental health treatment for distressed Muslims and aiding them in overcoming the stigma against mental health care. Generally, participants shared the belief that religious leaders are expected to be able to identify when a distressed Muslim needs a referral to mental health professionals and to subsequently provide a referral.

Participants viewed religious leaders as individuals who could facilitate treatment by helping remove emotional barriers. The act of a religious leader recommending treatment may be interpreted by community members as a license to discuss difficult issues in treatment. A female participant commented on case scenario 4 (about an unmarried woman who became pregnant), "So, the imam certainly [wants] to [have] longer conversations with the family and [connect] them with a professional and give clearance that this is okay to connect with the professional [as] well."

According to many of the imam participants, they are capable of giving advice on spiritual matters but would advise seeking help from a health professional regarding mental health issues. As one imam participant shared: "At least somebody that recognizes, okay, there's professionals outside of my capacity, and in addition, just say, from my capacity, this is what a person, you know, could do from the spiritual side. Here's some *dua* to read.... But go seek [out] a health professional."

Another imam specifically highlighted the various professions that were best suited to assist with such conditions:

> I think we'll be more effective as a community like that, because we have so many people who've gone to school. They are professional counselors. They are professional ther-

> apists. They're doctors. They're psychiatrists and psychologists. So, I think we should use all of that as a part of the solution.

Some participants expressed the view that the role of religious leaders and mental health professionals should not have any conceptual overlap and that there should be clear boundaries between the two roles. For example, a male participant stated,

> My understanding of imams is that [they] need to lead prayers, not diagnose medical issues. I have never been to an imam because I know he's not going to be able to listen to my problem. He has his own thing. . . . So, I think . . . there's a distinction between, you know, we have to provide medical attention to people who need medical attention, and [the] imam is there to lead prayers.

As indicated in the above quotes, many participants adamantly indicated their belief that mental health support did not fall within acceptable tasks for religious leaders. Rather, there was a strong preference for seeking help from professional counseling services in the community rather than from religious leaders alone.

Religious leaders who are aware of the limitations of their capacity will eventually advise community members to seek alternative help. An imam gave an example of how he dealt with a community member who asked for his help regarding a marriage dispute. He clearly distinguished the roles of religious leaders and counselors as different roles:

> In one situation, it was a marriage discord which eventually led to a divorce. It led to a divorce, but they asked me, can I do counseling? I said, "I don't do marriage and family counseling. I'm not a family counselor. But what I can do is, I've studied the *fiqh* of marriage. I can tell you the *fiqh* of marriage, but the *fiqh* of marriage and divorce is not going to solve your problems. You need to go to a counselor. But what I can offer to you as a service—I don't know this counselor that you're going to go to, but if they give you specific exercises or routines, ask my advice, and I'll give you the Islamic opinion."

In this context, the *fiqh* of marriage is the law of marriage based on the Quranic verses that regulate marriage and divorce among Muslim spouses. In this case, the imam made it clear that the *fiqh* of marriage is limited to advice on the ritual law that governs relationship matters between a husband and wife.

According to this subtheme, one of the role of religious leaders is to create and clarify the boundaries between their capacity to advise community members on spiritual matters and a professional that can advise on mental health matters.

Managing expectations of religious leaders

Given the lack of religious leaders' training in formal mental health counseling, as highlighted by the participants, levels of skill and ability with regard to mental illness identification and assistance would vary from imam to imam. Thus, in this theme, the participants discussed the limitations of current religious leaders and identified the training of and collaboration with imams in mental health care needed within the community.

Limitations of current religious leaders Some participants had doubts regarding the ability of religious leaders to provide socioemotional support for individuals in situations that are considered unambiguously sinful from an Islamic perspective (e.g., extramarital pregnancy) and that may result in experiences of stigma and stress. In the present study, for example, one female participant noted, in reference to case study 1, "[I] definitely agree

that maybe an imam isn't necessarily the best place to start just because a lot of imams have very close-minded cultural contexts."

Under these circumstances, a religious leader may be at best ineffective and at worst explicitly judgmental about a person's socioemotional difficulties and their associated mental health challenges. Furthermore, they may lack the necessary training that would allow them to address these difficulties appropriately. A young adult participant explained his response to case scenario 4:

> The second person you wouldn't go to is an imam that doesn't understand the situation or an imam that comes from a very cultural background because, for them, all they would see is the pregnancy and that's all. They wouldn't [necessarily] understand the pain, and the struggles, and the identity crisis, and everything else that's going on.

As demonstrated by this quote, some participants were concerned that religious leaders may be unable to provide emotional support to individuals who have transgressed religious teachings.

The imam participants were also aware that not all religious leaders have awareness of mental health issues. An imam expressed his view regarding selecting the appropriate religious leader to seek support from:

> I would say that in addition to going to that one imam, they should probably go to other imams, as well—and preferably an imam that knows about and has a respect for the mental health field, because there are imams in the community that are completely against mental health. And I'll give you one example. There was recently an imam here—a visiting imam. And he told people—he said, if you practice *tazkiyah*—[spiritual] purification of the heart—properly, you won't have any mental health issues at all . . . and he gives you proper *dhikr* [act of repetitive reflection on God] . . . you won't be dealing with any of these.[1]

According to many participants, training in mental health would supplement the knowledge base of religious leaders and support both the religious approach and medical intervention. However, participants also noted that the number of issues that religious leaders are expected to address in the community seems to create a demand that goes beyond the capacity of an imam. An imam participant noted that the community seeks the counsel of an imam in every aspect of their lives, thus making the imam the sole person handling community issues:

> So, even if the imam could help this person out, he is spread thin to begin with. But I agree also with the point that we have other professionals in the community. But sometimes, what happens with the Muslims is that they only feel that [the] *deen* [religion] can only come from the imam figures.

This subtheme highlights the limitations that imams might have and the need to balance their role in the community. Religious leaders who understand the difference

[1] In Islam, the practice of *tazkiyah* ("purifying the heart") or controlling one's bad intentions is done through performing *dhikr* or reciting the name of Allah repeatedly. The *dhikr* practice is believed to cleanse the heart, which might contribute to the improvement of mental health problems (Zarabozo, 2002).

between mental and spiritual issues should encourage community members to seek help from a professional apart from themselves to receive comprehensive care.

Training of and collaboration with imams in mental health care Participants shared ways in which they felt the challenges of religious leaders' roles in mental health could be addressed. This included helping community members overcome mental health challenges and addressing the stigma against mental illness. Many participants felt that the first step for imams to successfully address this aspect of their role in the community was through education. Participants highlighted the need for training about mental health specifically so imams could increase their knowledge about mental illness and mental health resources. A female participant mentioned, "But many of our imams are not trained, and I think it's important to train our imams about mental health because there's already a stigma outside of the *masjid* [mosque] related to mental health, mental illness, and mental wellness."

Participants indicated some technical and educational requirements that religious leaders should ideally complete in order to meet the community's needs. For instance, one female participant argued that training as a chaplain or in social services would be helpful for imams, indicating that "at the [very] least you must have some training as a chaplain. A chaplain and an imam are two different things. You must have some training with social services."

Many participants concurred that religious leaders were expected to have basic social service skills and fluency in English as well as cultural competency training to understand issues across diverse ethnocultural subpopulations of the Bay Area Muslim communities. Many participants also indicated that religious leaders needed to have specific trainings focused on distinguishing between spiritual challenges and mental health problems and to be able to then educate their congregations on those differences. An imam participant responding to case scenario 2 shared:

> I can't quote where—that Prophet Muhammad—*sallallahu alaihi wasallam* [peace be upon him]—said that we shouldn't seek a spiritual solution to a material problem. So, if there's something that's maybe chemical or physical that's wrong with the individual in terms of how their brain functions, then it's not going to be solved spiritually.

This theme overall highlights why basic training in mental health is necessary for religious leaders. In addition, an imam participant discussed that imams should be part of the community mental health care team. Furthermore, some imam participants also shared that on the side of mental health care, there is a lack of representation of, and support for, spiritual and religious leadership as a member of the team, as stated below:

> I would like to see, in addition to the community awareness programs, also imam training programs that not only are designed to help equip the imams with the knowledge or the awareness that they need to know about mental health issues in the community, but also respecting their position. So, if a mental health, you know, program were to come in, they have to recognize the imam's position within part of the mental health care team because we are, in most of the situations, the first people that they're going to come to. And based on our recommendation, that person is going to go to the mental health professional or not. So, because we're kind of the gatekeepers for the recipients of the care and the givers of the care, our position within the community has to be respected and recognized, and the awareness program built around that.

Overall, participants felt that there was a significant lack of training for imams related to the recognition of mental health disorders, aiding a community member struggling with mental health challenges, being able to distinguish spiritual challenges from mental health disorders, and the pastoral skills that come with roles such as chaplaincy. Community member participants felt that imams need to work together with mental health professionals in providing a comprehensive approach to meeting the mental health needs of Muslim individuals. In addition, imams also expressed the need to be included on the mental health team in the community.

Discussion

The current study is among the first to use a CBPR framework to explore the perceptions of Bay Area Muslims of the role of religious leaders in addressing mental health concerns. Previous literature on Muslim mental health suggests that Muslims in the United States were more likely to seek mental health support from religious leaders than from mental health professionals (Abu-Ras et al., 2008; O. Ali et al., 2005; Aloud & Rathur, 2009). Furthermore, data also suggests a significantly low utilization rate of mental health services within the American Muslim population for a variety of reasons, chief among them being the significant stigma around mental illness and mental health help seeking within Muslim American communities (Padela & Curlin, 2013). Thus, the present study aimed to understand the beliefs and perceptions of a community-based Muslim American sample regarding the role of religious leaders in the provision and support of mental health care, including both community members and imams.

Findings from the present study are consistent with previous research that highlights the multiple roles of religious leaders in Muslim communities. Imams assume roles as educators, counselors, and religious guides, often in contexts related to mental health (Abu-Ras et al., 2008; Chowdhury, 2016). However, the current study suggests that the perceptions Muslims hold about the role of religious leaders in mental health care are nuanced. For instance, in the current sample, some participants were hesitant to seek treatment directly from religious leaders, and others perceived the religious leader as a community liaison for mental health support. Some Muslims in the current sample reported that religious leaders play an important role in facilitating the treatment of mental health problems by referring congregants to professional care.

Muslims within this sample highlighted the fact that the primary role of the imams is to provide spiritual guidance and advice during challenging times by providing instruction on spiritual practices, offering lessons, and lending comfort through religious parables. Participants also highlighted that the role of imams extends to providing social and spiritual mediation, especially in regard to interpersonal challenges and conflict.

Furthermore, participants believed that religious leaders were well positioned in the community to advocate on behalf of distressed Muslims in need of mental health care. This echoes and supports past work on this topic. In addition to individual and family-level advocacy, findings from the current sample suggest that Muslims may view religious leaders (and imams view themselves) as voices in the community that can successfully challenge the mental illness stigma. This stigma in the Muslim community, including both the stigma of having a mental health problem and the stigma of seeking services, is a factor in preventing many Muslims from seeking treatment when needed (Ciftci et al., 2013; Zia & Mackenzie, 2021). Therefore, challenging the stigma may

be an effective strategy for imams in promoting mental health care (Zia & Mackenzie, 2021). As visible members of the community who are often seen leading prayers, teaching religious classes, and delivering lectures and sermons to their communities, religious leaders are individuals who may be able to leverage their preexisting roles to address mental health issues and engage in mental health promotion. Moreover, findings from the current sample suggest that Muslim Americans may perceive community-based mental health care promotion, which challenges stigma, as a role that falls under the purview of religious leaders.

Another interesting finding of the present study was that some participants held the expectation that religious leaders should remain up to date on contemporary issues in mental health, particularly as they relate to gender-specific challenges. These findings may be particularly relevant in addressing the needs of Muslim women, who face significant barriers to accessing mental health care due to both attitudinal and systemic barriers (Abu-Ras & Abu-Bader, 2008; S. Ali et al., 2022; Saleem & Martin, 2018). The availability of both male and female religious leaders who are trained in gender-specific issues may facilitate support seeking among Muslims, specifically Muslim women. Having both male and female leaders is even more important for certain culturally or religiously sensitive issues (e.g., relationship intimacy) given that some women may avoid seeking support for issues in those areas from male leaders out of a sense of modesty (Vu et al., 2017).

While the findings of this study are limited to one community of Muslims living in the Bay Area of California, this study is among the first to demonstrate the perception of the role of religious leaders held by members of the Muslim American community and the imams themselves as being distinct from that of mental health professionals. Some community members and imam participants indicated that religious leaders do not have the training required to provide evidence-based treatment for mental health problems, necessitating service provision by mental health professionals. However, our findings also suggest that the perceived distinction between the roles of mental health professionals and imams may be an opportunity to facilitate collaboration between these professions. These findings are consistent with a previous study that suggests that imams may play an important role in referring congregants for mental health services when needed (O. Ali & Milstein, 2012). Moreover, mental health providers may not have the same access to or influence on families or communities compared to religious leaders, especially given the persistent stigma associated with mental health care in the Muslim American community (Alhomaizi et al., 2018; Aloud & Rathur, 2009; Khan et al., 2019). Consequently, mental health education is critical for religious leaders to more fully understand the scope of their skills and their role as imams, to not inadvertently cause undue harm while working with community members, and to help community members recognize common mental health problems that require professional care (O. Ali & Milstein, 2012).

Despite endorsing roles where religious leaders can support positive mental health through implementing community strategies (e.g., Friday sermons), some participants in the current sample reported that mental health treatment was outside the scope of a religious leader's training and responsibility. In particular, both community members and imam participants reported beliefs that religious leaders lack knowledge of mental health care and consequently default to offering religious advice when clinical expertise is warranted. Moreover, some community member participants believed that religious leaders were not neutral in pastoral counseling, and therefore might be judgmental with congregants seeking support for difficulties that are inconsistent with Islamic religious values (e.g., extramarital pregnancy).

Consistent with previous research (Abu-Ras et al., 2008; O. Ali, 2016), participants indicated that religious leaders should seek additional training in mental health to better support distressed Muslims. Trainings of this nature could facilitate pastoral counseling skills to help distressed Muslims in their community feel more comfortable disclosing their emotional difficulties, especially in the context of acts that might be considered sinful. Some Muslim counseling centers, such as Maristan and the Khalil Center, provide trainings custom-tailored for imams to empower them to better address the needs of their congregants. However, to our knowledge, the effectiveness of these trainings has not yet been tested. Furthermore, trainings that utilize the chaplaincy model, include cultural competency training, and are focused on social service skills are possible ways to address the concerns participants brought up with the quality of training currently received by imams. Imams who are better trained in conducting assessments for psychological symptoms and who can help congregants feel comfortable disclosing these symptoms may be more likely to refer congregants to professional treatment when needed (Abu-Ras et al., 2008).

Limitations

The findings of the current study must be interpreted in the context of its limitations. First, participants' use of terminology for "religious leaders" differed. Whereas most participants appeared to contextually imply that the term "religious leader" referred to an imam, others used the term to refer to religious authority figures such as Islamic scholars and chaplains. In this paper, we included all of these figures under the broad categorization of religious leaders. However, it is important to note that the usage of these terms may not be interchangeable in every context. Future studies should investigate different religious leadership roles in the Muslim community as they relate to mental health care.

Finally, the current study did not collect complete demographic information from the participants. Given challenges with the method of recruitment of participants through the community advisory board, demographic information outside of gender and age was not collected. Focus groups were designed to capture a broad and inclusive range of Muslims. However, it is possible that different subgroups in the Muslim community view the role of religious leaders very differently. For example, highly religious Muslims may seek counseling exclusively from religious leaders. Therefore, future research should also investigate the role of religiosity in Muslims' perceptions of the roles of religious leaders.

Conclusion

This study is among the first to explore the perception of San Francisco Bay Area Muslims of the role of religious leaders in mental health care from the perspective of both community members and imams. Findings suggest Bay Area Muslims and local imams agree in their views of the types of roles religious leaders can have in improving access to mental health care. These include imams actively advocating for their congregants' mental health needs, referring Muslims in need of treatment to appropriate mental

health services, and challenging the stigma against mental health care in the broader community. However, community member participants appeared hesitant to seek direct treatment for mental health concerns from religious leaders. The roles of religious leaders and of mental health care providers, in the view of the current sample of Bay Area Muslims and imams, may therefore be distinct but complementary to each other. Future research is needed to systematically investigate future collaborations between these professions and to understand the nuances in various other subsets of the American Muslim community to help promote treatment to this often underserved community.

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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