The "Muslim" Dimension of Health Research

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OVERVIEW

- Present a sociocultural frameworks for understanding health behaviors and outcomes
  - Kleinman's Cultural Construction of Clinical Reality
  - Islamic Influences on Health Behaviors
- Discuss Measurement of "Muslim" Dimensions as Related to Health Outcomes
  - Religiosity
  - Muslim Identity
  - Ontology and Ethics

A group of people with some shared characteristics

-Identity
-Commitments
-Experiences
-Values
-History
-Beliefs

What do we mean when we use the term “Muslim”?

-Applying the label suggests a “lumping” activity
-It signifies something is uniquely shared, makes this group same within-group but different from those outside of group

BACKGROUND

- Traditional religion and health research focused on the impact of generalized religiosity, without much attention to the different structures of religious traditions
  - Self-reported religiosity and relationship to blood pressure
- Health disparities research groups individuals by race, ethnicity, and socioeconomic status
  - Because of unique political and social hx of US
  - Assumes relevant health-related beliefs, experiences, and cultures aggregate by such categories
- Group dynamics and religiosity
  - Religiosity acts independently on health when comparing people from the same ethnic, but different religious groups[3]
  - Particularized religiosity (e.g. fatalism) may have different structure and relationships to health in different groups

BACKGROUND

- Muslims are racially, ethnically, and socioeconomically diverse
  - Predominant subgroups: native-born African Americans, immigrants from South Asia, and immigrants from the Middle East
- While each subgroup has its own social and cultural history, there is a shared religious worldview that can shape its members' health-related behaviors and healthcare interactions, and they may share social experiences that impact health
- The promise: Studies have suggested the Muslim religiosity can both hinder and promote the health of American Muslims
  - Diversity of the community allows us to "isolate" how shared religion, independently, influences health across racial, ethnic, and socioeconomic lines

Kleinman's Cultural Construction of Clinical Reality[1]

KLEINMAN'S STRUCTURAL DOMAINS OF HEALTH CARE IN SOCIETY

- Illness is handled in domains, each of which possess their own explanatory systems, social rules, interaction settings, and institutions

- Cultural construction of clinical reality
  - Explanatory models that are used by patients and providers to engage with illness and healthcare
  - Culturally-constituted and vary across the domains of healthcare as well as groups in the same society

KLEINMAN'S STRUCTURAL DOMAINS OF HEALTHCARE IN SOCIETY

- Domains
  - Professional → Religiosity and Health Behavior
    - Allopathic
  - Popular → Health Decision Making
    - Family, social networks, community
  - Folk → Etiology of Disease & Ontology of Cure (as above)
    - Non-professional healers and alternative treatments

- How do these domains relate to "Muslim" communities?
- How may they be studied in your work?

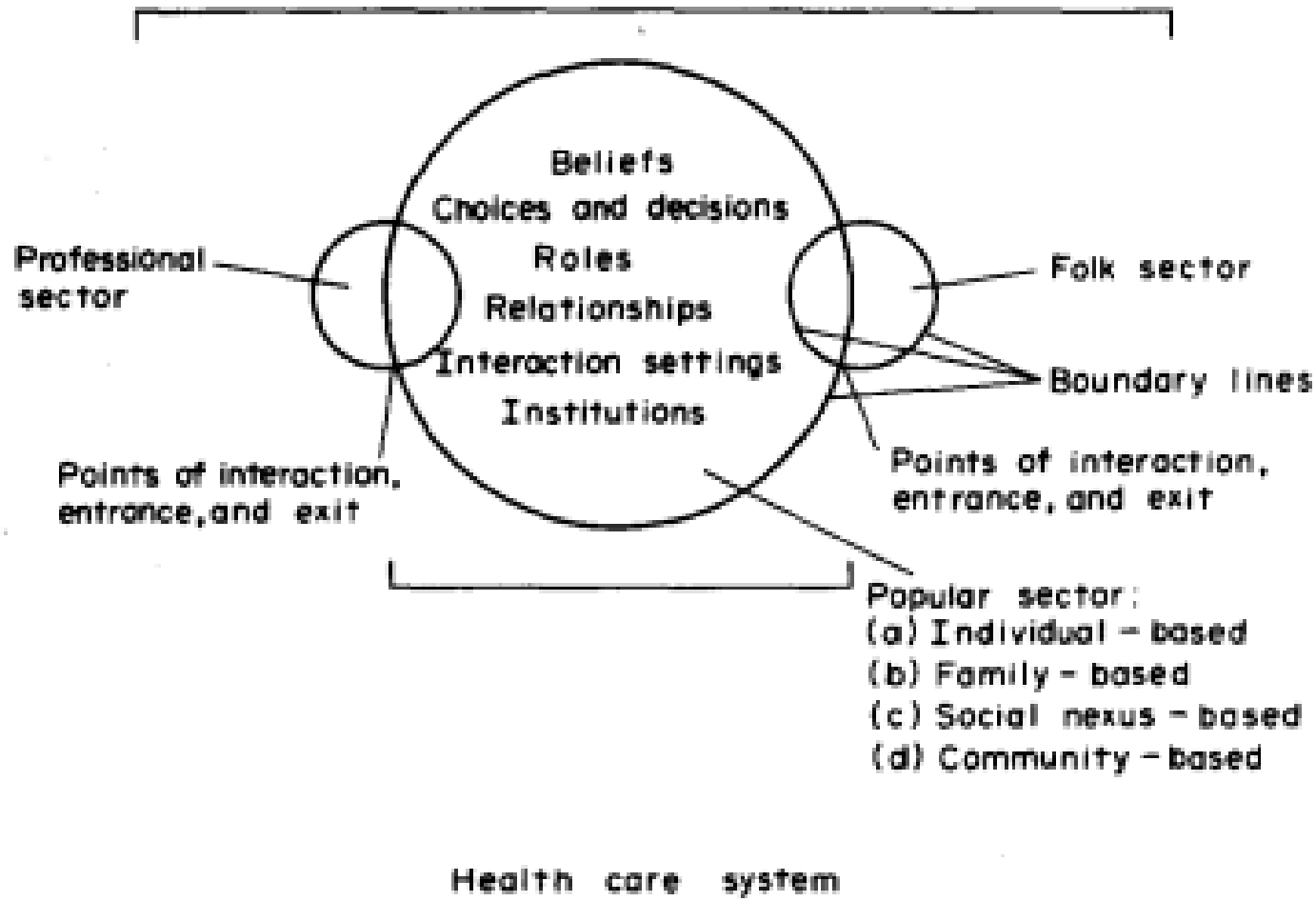


Fig. 1. Health care system: internal structure.

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine. Part B: Medical Anthropology*, *12*, 85-93.

MOVING FROM DESCRIPTIVE TO OUTCOMES RESEARCH

- Religion can contribute to this cultural construction of clinical reality by shaping the way individuals perceive, label, and evaluate their illnesses (health beliefs and behaviors)

- Discordant views of clinical reality (between patient and provider) can result in improper clinical management (health disparities and poor outcomes)

PRACTICAL ADVICE

- Use Kleinman's three domains to elicit narratives of moving from illness to health for your area of research
  - How do Muslim youth deal with complications of alcoholism?
- Use and or develop measurement tools within each domain and to understand interaction within that realm or relationships among them
  - Is religiosity protective against alcoholism?
  - Does have strong religious identity prevent help-seeking?
  - Do Imams provide a source of counsel or prescribe ruqya for alcoholism?

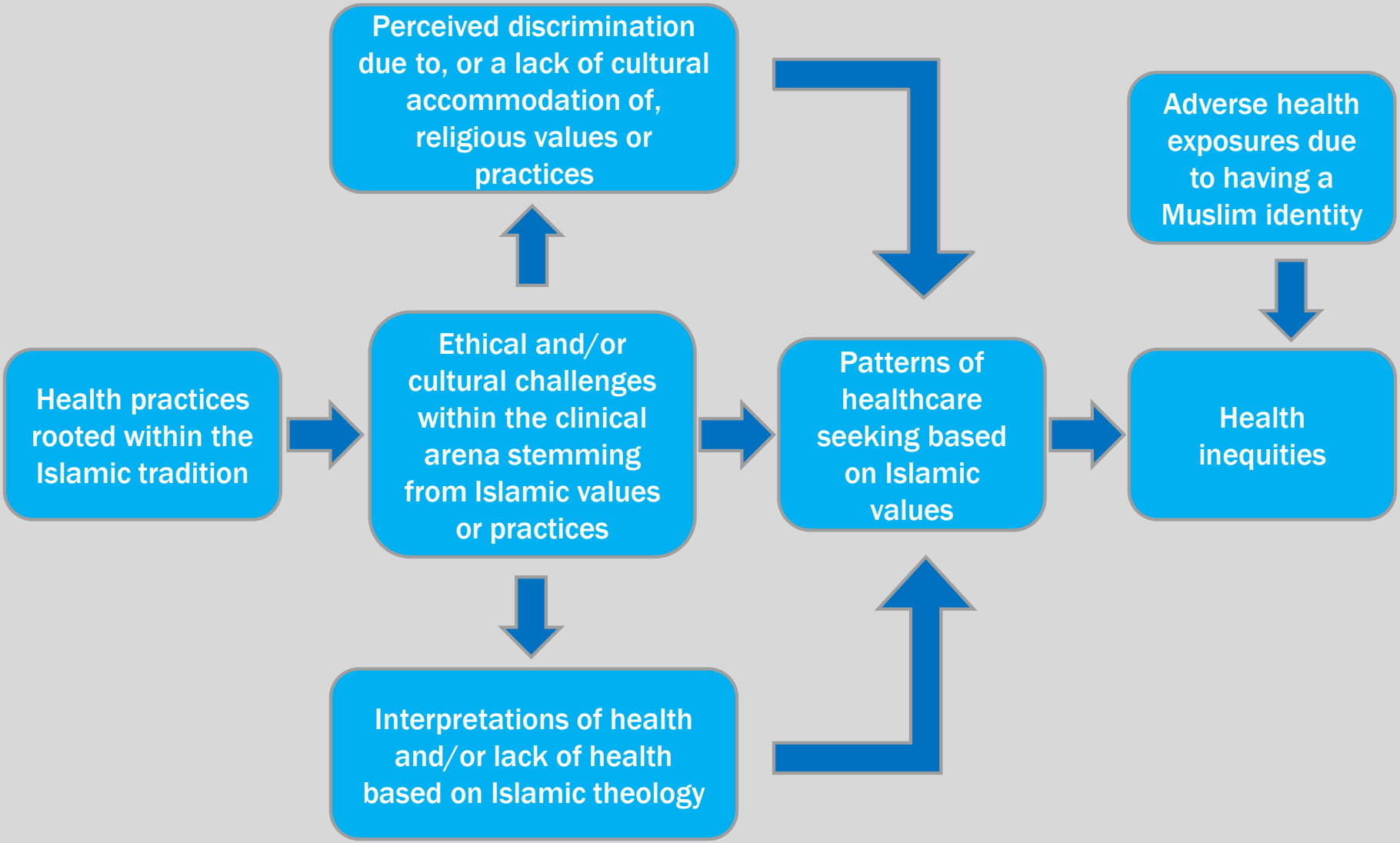
HEALTH THROUGH THE "MUSLIM LENS"

- God-centered view of healing[2]
  - Actors:
    - Doctors, imams, family and community are sources of healing
  - Means:
    - Worship, medicine, herbs, and text-based practices can produce healing
  - Health and illness are controlled by God's decree → humans play a secondary, but complementary role

HEALTH THROUGH THE "MUSLIM LENS"

- Construction of health
  - Health : Spiritual, Social, Physical
    - Spiritual failings may → physical illness[8]
- Construction of disease
  - Pregnancy is a "blessing"→ not in favor of contraception[5]
  - Cancer may be fate → prevention not a priority[7]
- How might these ideas related to the Kleinman's domains? Study methods and tools? Health Outcomes?

Mechanisms through which Islamic Identity Can Contribute to Health Inequities



Padela, A. I., & Zaidi, D. (2018). The Islamic tradition and health inequities: A preliminary conceptual model based on a systematic literature review of Muslim health-care disparities. *Avicenna journal of medicine*, *8*(1), 1.

The Why:
Generate New Knowledge, Provide Evidence for Guidelines, Policies and Advocacy Efforts

American Muslim Health Disparities: The State of the Medline Literature

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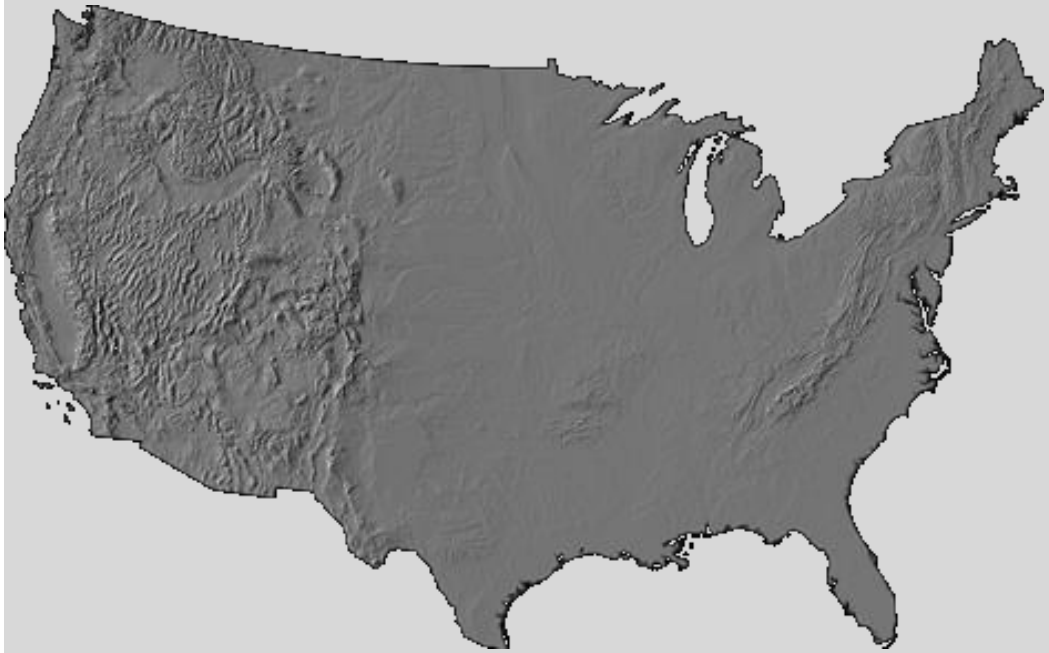


From 1970-2009

- Muslim & America & Health Disparity → 2 articles
- Muslim & America & Disparities → 10 articles

STUDYING MUSLIM HCD IN US

- Used "ethnic/racial/geographic" proxy for Muslims → marginal improvement
  - 171 empirical investigations
    - 42 studied Arab Americans; 41 South Asians
      - → These populations may include non-Muslims
    - 19 (only) considered religion to possibly contribute to health differences
      - → Islam not an important determinant of health behaviors

- Some local projects → convenience samples ➔ non-comprehensive distorted picture

- Analogy:
  - One partial hadith with questionable narrator → sunnah

THE PROFESSIONAL DOMAIN OF HEALTHCARE: RELIGIOSITY AND HEALTH BEHAVIOR

TOOLS FOR MEASURING RELIGIOSITY AND HEALTH BEHAVIOR

- **Religion-Related Measures**
  - Duke University Religion Index (DUREL)[9]
    - A measure of religious practice that evaluations Organizational Religious Activity (ORA) and Non-Organizational Religious Activity (NORA)
  - Psychologic Measure of Islamic Religiousness (PMIR)[10]
    - Intrinsic & Coping Mechanism
  - Modesty
    - Correlated with religiosity
  - Fatalism
    - Correlated with religiosity

- **Methods for Measuring Health Behavior**
  - Surveys (face-to-face, email, telephone, mail, web)

The Duke University Religion Index (DUREL): A Five-Item Measure for Use in Epidemological Studies

Harold G. Koenig [1,*] and Arndt Büssing [2]

Table 1. Items of the Duke University Religion Index (DUREL).

(1) How often do you attend church or other religious meetings? (ORA)
1 - Never; 2 - Once a year or less; 3 - A few times a year; 4 - A few times a month; 5 - Once a week; 6 - More than once/week
(2) How often do you spend time in private religious activities, such as prayer, meditation or Biblestudy? (NORA)
1 - Rarely or never; 2 - A few times a month; 3 - Once a week; 4 - Two or more times/week; 5 - Daily;6 - More than once a day
The following section contains 3 statements about religious belief or experience. Please mark theextent to which each statement is true or not true for you.
(3) In my life, I experience the presence of the Divine (*i.e.*, God) - (IR)
1 - Definitely *not* true; 2 - Tends *not* to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me
(4) My religious beliefs are what really lie behind my whole approach to life - (IR)
1 - Definitely *not* true; 2 - Tends *not* to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me
(5) I try hard to carry my religion over into all other dealings in life - (IR)
1 - Definitely *not* true; 2 - Tends *not* to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

A Psychological Measure of Islamic Religiousness: Development and Evidence for Reliability and Validity

Hisham Abu Raiya [a]; Kenneth I. Pargament [a]; Annette Mahoney [a]; Catherine Stein [a]
[a] Bowling Green State University,

Table 1 The Five Core Islamic Dimensions and Sample Items

Dimension	Definition	Sample item
1. Islamic beliefs	Basic Islamic beliefs about the world	I believe in the existence of Allah
2. Islamic practices	Basic Islamic practices to demonstrate adherence to Islam	How often do you pray?
3. Islamic ethical conduct dos	Basic ethical guidelines that Muslims are encouraged to follow	Islam is the major reason why I honor my parents
4. Islamic ethical conduct don'ts	Basic behaviors and attitudes that are discouraged among Muslims	Islam is the major reason why I do not drink alcohol
5. Islamic universality	The degree to which a Muslim perceives himself/herself as belonging to the larger Islamic nation	I consider every Muslim as my brother or sister

MEASURE FOR MUSLIM MODESTY-WOMEN

Items measured on a 4-point agreement scale from (1) Completely Disagree to (4) Completely Agree	
Item 1	"When I am in a mixed gender gathering or outside of the home, I cover my entire body, except my hands and face"
Item 2	"When I have guests at my home, men and women sit separately"
Item 3	"I always look for a female doctor for myself"
Item 4	"I have delayed seeking routine care or primary care when no woman doctor is available to see me"
Item 5	"An unmarried man and unmarried woman should not be alone together"
Item 6	"Hospital gowns are not modest"
Item 7	"My clothing demonstrates a commitment to Islamic modesty"
Item 8	"Modesty affects a woman's physical contact with men other than her husband"
Item 9	"Modesty requires separation between the sexes in public gatherings"
Item 10	"Modesty is the essence of who we are as Muslims"

Development and validation of a religious health fatalism measure for the African-American faith community.

Franklin MD[1], Schlundt DG, Wallston KA.

Abstract

Health researchers struggle to understand barriers to improving health in the African-American community. The African-American church is one of the most promising venues for health promotion, disease prevention, and disparities reduction. Religious fatalism, the belief that health outcomes are inevitable and/or determined by God, may inhibit healthy behaviors for a subset of religious persons. This study reports the development and validation of the Religious Health Fatalism Questionnaire, a measurement tool for studying faith-related health beliefs in African-Americans. Participants included 276 members of seven predominantly African-American churches. Factor analysis indicated three dimensions: (1) Divine Provision; (2) Destined Plan; and (3) Helpless Inevitability. Evidence is presented for the reliability, convergent and predictive validity of the Religious Health Fatalism Questionnaire.

RHFQ-MUSLIM

Items measured on a 4-point agreement scale from (1) Completely Disagree to (4) Completely Agree	
Item 1	"If a person has enough faith, healing will occur without doctors having to do anything." (Divine Provision subscale)
Item 2	"I do not worry about my health because it is in Allah's hands." (Divine Provision subscale)
Item 3	"If I become ill, Allah has intended that to happen." (Destined Plan subscale)
Item 4	"Whatever illness I will have, Allah has already planned them." (Destined Plan subscale)
Item 5	"If I am sick, I have to wait until it is Allah's time for me to be healed." (Divine Provision subscale)
Item 6	"When I have a health problem, I pray for Allah's will to be done." (Divine Provision subscale)
Item 7	"I trust Allah, not man to heal me." (Divine Provision subscale)
Item 8	"Sometimes Allah allows people to be sick for a reason." (Destined Plan subscale)

OTHER CONSIDERATIONS

- Focus groups have demonstrated that some American Muslims are concerned about:[25]
  - Gender-concordant care
  - Halal food in the healthcare setting
  - Access to neutral prayer spaces

- Lack of such cultural accomodations may be interpreted as discrimination and/or impact healthcare-seeking decisions [more later]

Table 2

Major US Surveys That Measure Health Behaviors

Acronym	Name	Sponsoring Agency
ACS	American Community Survey	US Census Bureau
BRFSS	Behavioral Risk Factor Surveillance System	CDC
CPS	Current Population Survey	US Census Bureau
CSFII	Continuing Survey of Food Intakes by Individuals	US Department of Agriculture
CSHCN	National Survey of Children with Special Health Care Needs	CDC
IFPS	Infant Feeding Practice Study II	CDC
IHIS	Integrated Health Interview Series	NCHS-NHIS

Mokdad, A. H., & Remington, P. (2010). Measuring health behaviors in populations. *Preventing chronic disease*, *7*(4).

THE POPULAR DOMAIN OF HEALTHCARE: MUSLIM HEALTH DECISION-MAKING

THE POPULAR DOMAIN OF HEALTHCARE

- Most decisions regarding when to seek aid in other arenas, whom to consult, and whether to comply, along with most lay evaluations of the efficacy of treatment are made in this domain[1]
- Accounts for 70-90% of healthcare[1]
- How does your Muslim study population interact with this domain?
- Are their other important considerations that Muslims may have about health seeking making them stay in this domain and not the professional?

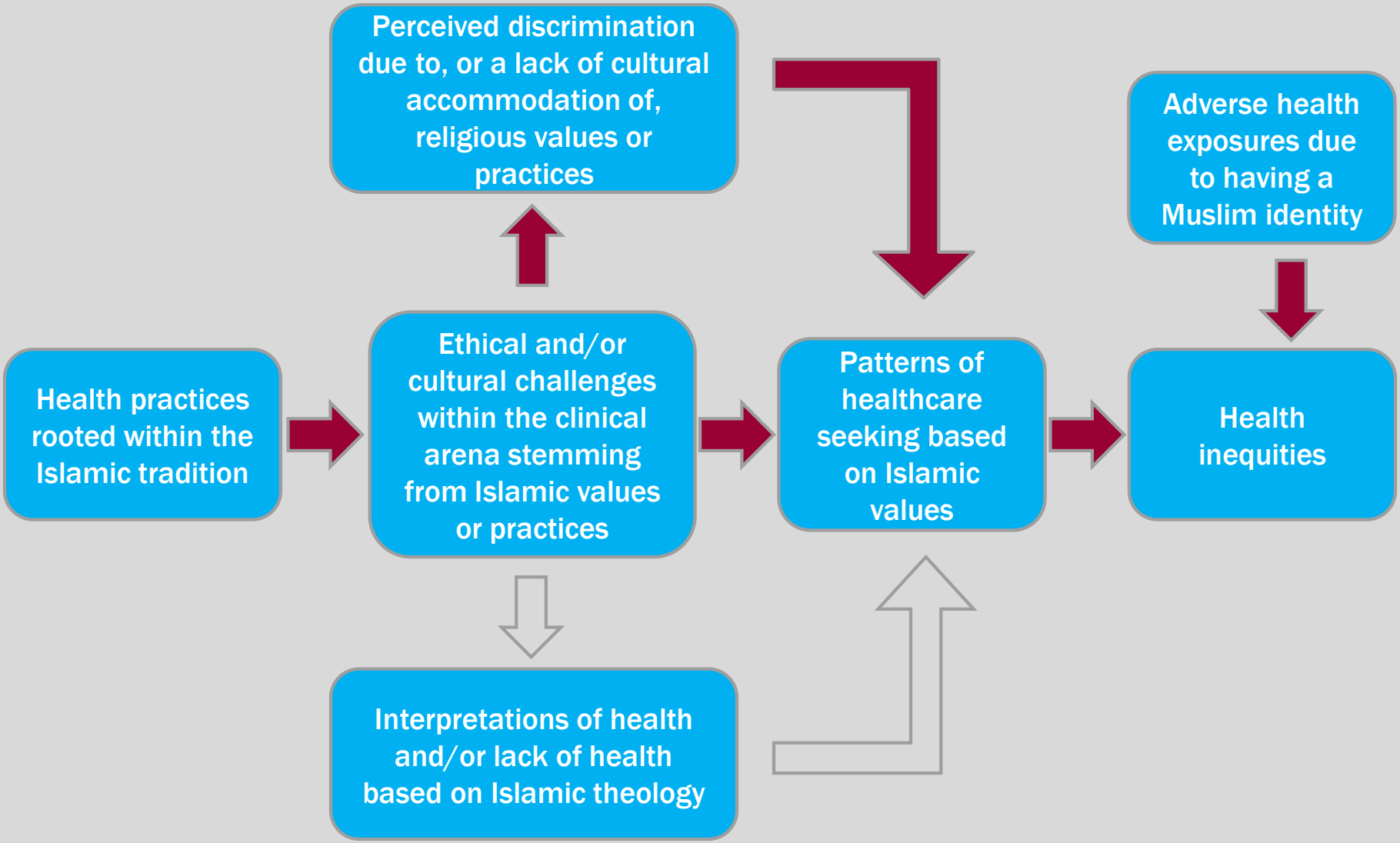
ETHICO-LEGAL FRAMEWORK

- Certain behaviors may be motivated & others restricted[2]
  - Breast feeding of children → health benefits
  - Reduced alcohol consumption → health benefits
  - Restricted abortion → children with developmental delay or special needs
- Governs treatment acceptance and manner of receipt[2]
  - Porcine based medications may be proscribed → attitudes towards vaccination
  - Gender concordance → influences healthcare seeking patterns across a variety of conditions

A SOCIALLY-MARGINALIZED IDENTITY

- Post-9/11 discrimination & Islamophobia
  - Abuse and Discrimination →
    - Increased psychological distress and lower levels of happiness[11]
  - Upsurge in hate crimes and negative stereotypes[12]
    - Hate crimes against Muslims reported to the FBI increased from 28 in 2000 to 481 in 2001 → hovered between 100-160 per year from 2002-2014

How Discrimination Impacts Health Decision-Making



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IMPACT OF DISCRIMINATION AND ISLAMOPHOBIA ON HEALTH

- Increased discrimination may lead to:
  - Maladaptive behaviors [13,14]
    - Social isolation, avoiding healthcare, smoking, etc
  - Stress-related illnesses[15]
  - Poor mental health[15,16]
    - Increases in major depression and generalized anxiety symptoms
  - Delayed healthcare-seeking or worse preventive health

MEASURES OF DISCRIMINATION

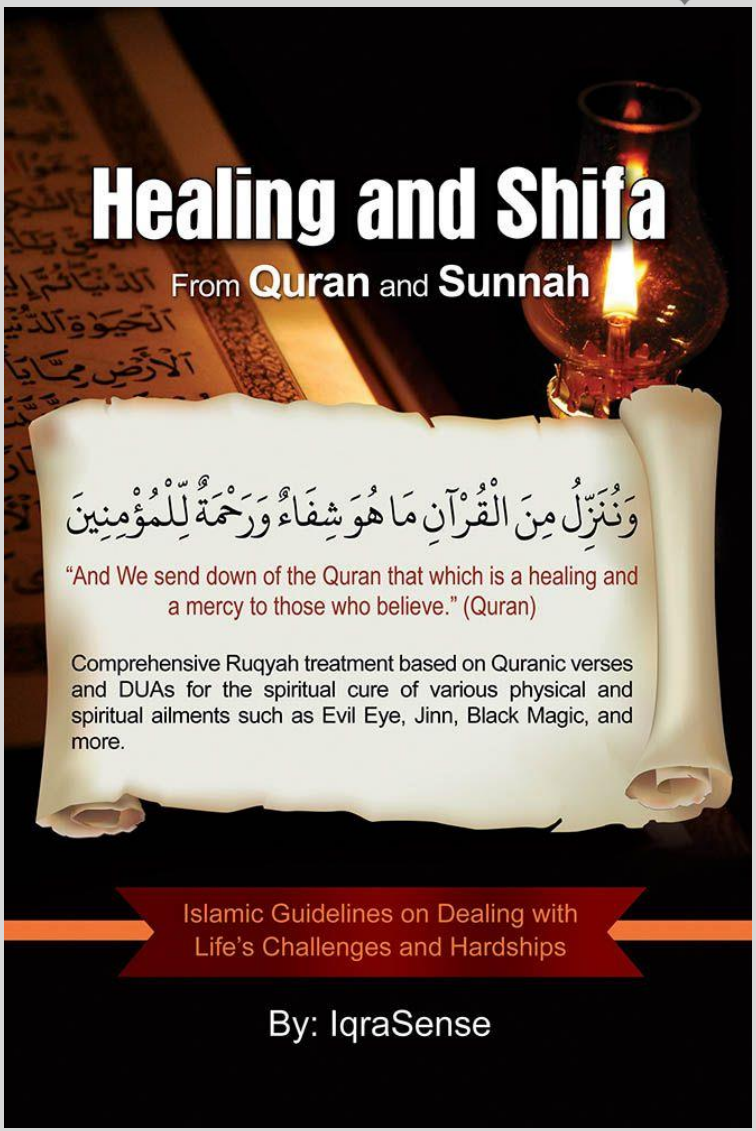
- Discrimination in Medical Settings Scale[17]
- Perceived Racism Scale[18]
- Telephone Administered Perceived Racism Scale[19]
- Perceptions of Racism Scale[20]
- Index of Race-Related Stress[21]
- Perceived Ethnic Discrimination Questionnaire[22]

OTHER CONSIDERATIONS

- Concerns of gender-concordant care → less frequent healthcare seeking
- Concerns about modesty → impact rates of cervical and breast cancer screening

ETIOLOGY OF DISEASE AND ONTOLOGY OF CURE

Caricatures of American Muslim Health



CARE-SEEKING BEHAVIOR

- Rather than seeking healthcare within the professional domain, American Muslims may emphasize spiritual causes of illness and therefore seek to address illness within the spiritual domain
  - Psychiatric conditions as a result of spiritual possession[6]
  - Illness as a result of spiritual failings[8]
  - Religious rituals and worship practices for healing[23]
  - Traditional, folk healing practices such as cupping[24]

SUMMARY

- Religion, despite having the potential to influence health, is not recognized as a factor on a national scale
- Religion acts alongside, not within, other health indicators such as race, ethnicity, and socioeconomic status
- Religiosity, while able to impact health negatively, can also facilitate positive health behaviors and, ultimately, outcomes[4]
- Religion-associated health disparities are impossible to study without the proper tools and a priori frameworks of behavior

NOW LET'S THINK ABOUT YOUR PROJECTS…

QUESTIONS TO CONSIDER

- What types of explanatory models might you be dealing with?
  - What are potential areas of discordance and concordance?
- Which “domain” of cultural construction is going to have the largest impact on your project?
  - How will this help?
  - How might it harm?
- What health outcomes are you going to be impacting? Health seeking behaviors? Decision making?

REFERENCES

1. Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine*, *88*(2), 251-258.
2. Padela, A. I., & Curlin, F. A. (2013). Religion and disparities: Considering the influences of Islam on the health of American Muslims. *Journal of religion and health*, *52*(4), 1333-1345.
3. Karlsen, S., & Nazroo, J. Y. (2010). Religious and ethnic differences in health: Evidence from the Health Surveys for England 1999 and 2004. Ethnicity & Health, 15(6), 549–568.
4. Laird, L. D., Amer, M. M., Barnett, E. D., & Barnes, L. L. (2007a). Muslim patients and health disparities in the UK and the US. [Review]. Archives of Disease in Childhood, 92(10), 922–926.
5. Beine, K., Fullerton, J., Palinkas, L., & Anders, B. (1995). Conceptions of prenatal care among Somali women in San Diego. Journal of Nurse-Midwifery, 40(4), 376–381.
6. Padela, A. I., Killawi, A., Heisler, M., Demonner, S., & Fetters, M. D. (2011). The role of imams in American Muslim health: perspectives of Muslim community leaders in Southeast Michigan. J Relig Health 123 [Research Support, Non-U.S. Gov't]. Journal of Religion and Health, 50(2), 359–373
7. Johnson, J. L., Bottorff, J. L., Balneaves, L. G., Grewal, S., Bhagat, R., Hilton, B. A., et al. (1999). South Asian womens' views on the causes of breast cancer: Images and explanations. Patient Education and Counseling, 37(3), 243–254.
8. Franklin, M. D., Schlundt, D. G., McClellan, L. H., Kinebrew, T., Sheats, J., Belue, R. et al. (2007). Religious fatalism and its association with health behaviors and outcomes. [Research Support, N.I.H., Extramural Research Support, U.S. Gov't, P.H.S.]. American Journal of Health Behavior, 31(6), 563–572.
9. Koenig, H. G., & Büssing, A. (2010). The Duke University Religion Index (DUREL): A five-item measure for use in epidemological studies. *Religions*, *1*(1), 78-85.
10. Abu Raiya, H., Pargament, K. I., Mahoney, A., & Stein, C. (2008). A psychological measure of Islamic religiousness: Development and evidence for reliability and validity. *The International Journal for the Psychology of Religion*, *18*(4), 291-315.
11. Padela, A. I., & Heisler, M. (2010). The association of perceived abuse and discrimination after September 11, 2001, with psychological distress, level of happiness, and health status among Arab Americans. *American journal of public health*, *100*(2), 284-291.
12. United States Department of Justice, Federal Bureau of Investigation. Hate Crime Statistics, 2000-2014.

REFERENCES

13. Brown, T. N., Williams, D., Jackson, J., Neighbors, H., Torres, M., Sellers, S. L., et al. (2000). ''Being black and feeling blue'': The mental health consequences of racial discrimination. Race and Society, 2, 117–131.
14. Williams, D., Neighbors, H., & Jackson, J. (2003). Racial/ethnic discrimination and health: Findings from community studies. American Journal of Public Health, 93(2), 200–207.
15. Shah, S. M., Ayash, C., Pharaon, N. A., & Gany, F. M. (2008). Arab American immigrants in New York: Health care and cancer knowledge, attitudes, and beliefs. Journal of Immigrant and Minority Health, 10(5), 429–436
16. Samari, G. (2016). Islamophobia and public health in the United States. *American journal of public health*, *106*(11), 1920-1925.
17. Peek, M. E., Nunez-Smith, M., Drum, M., & Lewis, T. T. (2011). Adapting the everyday discrimination scale to medical settings: reliability and validity testing in a sample of African American patients. *Ethnicity & disease*, *21*(4), 502.
18. McNeilly, M. D., Anderson, N. B., Armstead, C. A., Clark, R., Corbett, M., Robinson, E. L., ... & Lepisto, E. M. (1996). The perceived racism scale: a multidimensional assessment of the experience of white racism among African Americans. *Ethnicity & disease*, *6*(1-2), 154-166.
19. Vines, A. I., McNeilly, M. D., Stevens, J., Hertz-Picciotto, I., Bohlig, M., & Baird, D. D. (2001). Development and reliability of a Telephone-Administered Perceived Racism Scale (TPRS): a tool for epidemiological use. *Ethnicity & disease*, *11*(2), 251.
20. Green, N. L. (1995). Development of the perceptions of racism scale. *Journal of Nursing Scholarship*, *27*(2), 141-146.
21. Utsey, S. O., & Ponterotto, J. G. (1996). Development and validation of the Index of Race-Related Stress (IRRS). *Journal of Counseling Psychology*, *43*(4), 490.
22. Brondolo, E., Kelly, K. P., Coakley, V., Gordon, T., Thompson, S., Levy, E., ... & Contrada, R. J. (2005). The Perceived Ethnic Discrimination Questionnaire: Development and Preliminary Validation of a Community Version 1. *Journal of Applied Social Psychology*, *35*(2), 335-365.
23. Morioka-Douglas, N., Sacks, T., & Yeo, G. (2004). Issues in caring for Afghan American elders: Insights from literature and a focus group. Journal of Cross-cultural gerontology, 19(1), 27–40.
24. Alrawi, S., Fetters, M. D., Killawi, A., Hammad, A., & Padela, A. (2011). Traditional healing practices among American muslims: Perceptions of community leaders in Southeast Michigan. Journal of Immigrant and Minority Health.
25. Padela, A. I., Gunter, K., Killawi, A., & Heisler, M. (2012). Religious values and healthcare accommodations: voices from the American Muslim community. *Journal of general internal medicine*, *27*(6), 708-715.