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POJHA ÑAÑA
Materie Medica Misionera
o
Herbario de las Reducciones Guaranies
Misiones
Año de 1725
por
MARCOS VILLODAS S.J.

AGEM 1970–2010: 40 Jahre Forschen im „Interdisziplinären Arbeitsfeld Ethnologie & Medizin“. Rückblick und Ausblicke II: Anwendungen

Zum Titelbild/Cover picture 33(2010)3+4:

Abbildungen zu Artikeln aus diesem Heft:
links: die Göttin Tanit (Ibiza) / **Mitte oben:** Der Patient als Integrator; **unten:** Ifa-Orakelbrett /
rechts oben: Flowers in Memory of Mortal Road Accidents, Lady Diana in Paris;
unten: Ethnobotanik der Guarani 1725

Figures of articles in this issue:
left: Goddes Tanit (Ibiza) / **middle up:** The Patient as Integrator; **below:** Ifa-oracle /
right above: Flowers in Memory of Mortal Road Accidents, Lady Diana in Paris;
below: Guarani Ethnobotany in 1725.

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Geschäftsadresse / office AGEM: AGEM-Curare
c/o E. Schröder, Spindelstr. 3, 14482 Potsdam, Germany
e-mail: ee.schroeder@t-online.de, Fax: +49-[0]331-704 46 82
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Islamophobia and Mental Health of Muslims in the UK Post September 11, 2001*

Simon Dein & Kalpana Dein

Abstract This paper is divided into two parts. First we briefly review the literature examining mental health problems among British Muslims. I then move on to examine Islamophobia and its mental health consequences. There is evidence that Islamophobia has increased in the West after the atrocities of September 11 2001. Like other forms of discrimination and racism, Islamophobia is associated with poorer mental health outcomes. The importance of sensitising psychiatrists to the impact of discrimination is emphasised.

Keywords Islamophobia – mental health – Muslim – UK

Seelische Gesundheit der britischen Muslime im Zeichen der Islamophobie. Entwicklungen seit dem 11. September 2001

Zusammenfassung Es werden in diesem Beitrag zwei Themen vorgelegt. Zuerst geben die Autoren einen kurzen Überblick zur Literatur über psychische Probleme bei britischen Muslimen. Es wird darauf die neue „Islamophobie“ und die Folgen für die seelische Gesundheit untersucht. Dabei ist augenfällig, dass das Ansteigen der „Islamophobie“ im unmittelbaren Zusammenhang mit den Ereignissen des 11. September 2001 steht. Wie bei anderen Formen von Diskriminierung und Rassismus führt das Phänomen zu einer Verschlechterung der seelischen Gesundheit. Die Wichtigkeit, Psychiater für die drohenden Gefahren durch Diskriminierung zu sensibilisieren, wird hervorgehoben.

Schlagwörter Fremdenfeindlichkeit – Islamophobie – seelische Gesundheit – Muslime – Großbritannien

Introduction: Islam and Mental Health

In the UK there are 1.6 million Muslims who comprise over half of the UK's non-Christian population, 74% are of Asian background. They constitute the largest religious minority group in Britain. Although this paper focuses upon Islamophobia, we shall first briefly outline existing research on Islam and mental health. To date studies of Muslim mental health in the UK have focused on three areas: the underutilisation of mental health services (Patel *et a*l. 2000); depression (Hussain & Cochrane 2004); and spirit possession (Dein, Alexander & Napier 2008, Khalifa & Hardie 2005). Muslim people in the UK suffering with mental disorders are reluctant to use mainstream services. Bradby *et al*. (2007) examined the underuse of child psychiatry services among British South Asians. Stigma and perceived feelings of discrimination by health professionals emerged as significant barriers to service use in this group.

Inayat (2005) examined barriers to utilization of mental health services by Muslim clients and suggested that therapists need to take care when interpreting client distress in a multicultural setting. He highlights six areas of functioning which impact on underutilization of mental health services in Muslim clients. These are: mistrust of service providers, fear of treatment, fear of racism and discrimination, language barriers, differences in communication, issues of culture.

There is evidence that mental illness is frequently seen as a religious problem which is commonly attributed to possession by jinn spirits or to witchcraft (Dein, Alexander & Napier 2008). Imams and traditional healers are frequently the first resort, and mainstream psychiatry is seen as stigmatizing. Recitation of various sura from the Qur'an is commonplace. Patients' families play a significant role in determining pathways into religious rather than medical care.

* A version of this paper was presented at the WACP (World Association of Cultural Psychiatry) at conference, Norcia, Italy, 28 Sept., 2009.

Depression, suicide and self-harm emerge as significant problems for South Asian women, particularly young women (ANAND & COCHRANE 2005). Young women from South Asian backgrounds face a number of barriers to accessing support. These include the male privilege existing in some communities and families, the difficulty that some associated with being part of a tight-knit community, and the idea of family honour (*izzat*). Social isolation, language problems and the anticipation of racism and cultural exclusion significantly affect women's access to mental health care.

Islamophobia

One form of discrimination which appears to have increased in Europe in the past decade is Islamophobia, a term which first appeared in the Oxford English dictionary in 1997 and refers to the exclusion of Muslims, or discrimination and violence against them. In European discourse, the terms Islamophobia and xenophobia are often favoured over the term racism. Like other forms of prejudice and discrimination, it may be expressed in a variety of forms: in everyday conversation, through media representations, through discriminatory employment practices, in the provision of health, education and other services. In extreme cases it may result in, aggression—verbal abuse, vandalism, or physical violence. Islamophobia is not only a Western phenomenon: despite being a sizeable minority, Muslims in India complain about discrimination by Hindus. However, the legitimacy of the term has been debated by academics who question how this concept differs from racism, anti-Islam and anti-Semitism. They point out that it is imprecisely applied to diverse phenomena, ranging from xenophobia to anti-terrorism.

The *Runnymede report* identified a number derogatory and vilifying perceptions of Islam related to Islamophobia: monolithic, static and unresponsive to change, lacking values in common with other cultures, barbaric, irrational and sexist, violent and supportive of terrorism, a political ideology used for political or military purposes and therefore hostility towards Islam is used to justify discriminatory practices towards Muslims and exclusion of Muslims from mainstream society (RUNNYMEDE TRUST 1997). This negative perception of Islam has a long historical legacy, dating back to confrontations between the Muslim world and Europe, from the Crusades to colonialism and its aftermath. Predating the events of September 11, the Rushdie Affair in 1989 where there was public burning of Rushdie's Satanic verses in Bradford concretised the place of Muslims in the public sphere. The media portrayed Muslims as 'uncivilised', 'intolerant', homogenous in their anti-modern views; attitudes that were further reinforced by a *fatwa* by Ayatollah Khomeini calling for the death of SALMAN RUSHDIE. There was little attention given to Muslims' own perceptions of offence deriving from these events. Media reporting in the 1990's of an undefined global movement, "Islamic Fundamentalism", who make political demands that pose a threat to the established western social and philosophical order, further reinforced the perception of Muslims as violent fundamentalists and fanatics.

Islamophobia since September 11

There has been little empirical research conducted on the subject of specifically religious (as opposed to racial) discrimination and the distinction between racism and religious discrimination is often blurred. Because Muslims are frequently represented as coming from non-white groups, they undergo a process of "differential racialisation" whereby their religious identity is often directly or indirectly linked with racial identity (LAIRD 2007). Muslims in the UK and in the USA are differentiated by race (black, white) and ethnicity (e.g. South Asian, Arab, West African), national origin, social class and immigration status. Islamophobia may co-exist or override these other distinctions while not eliminating them.

A Home Office Research Study examined religious discrimination in England and Wales across 20 faith groups. Ignorance about religions, and indifference toward them were cited as significant concerns across faith groups (WELLER, FELDMAN & PURDAM 2001). Importantly, Muslim organisations reported higher levels of perceived unfair treatment in education, housing, employment and law than the majority of other faith groups. Muslims were the most likely group to report that religious discrimination had increased since 1996.

The European Monitoring Centre on Racism and Xenophobia reported increased hostility towards Muslims after the terrorist attacks of September 11th (ALLEN & NIELSEN 2002). These incidents included

verbal abuse, a tendency to blame all Muslims for the terrorism, forcibly removing women's hijabs, spitting on Muslims, calling children "Osama" as well as random physical assaults. Verbal abuse, harassment, and aggression were more prevalent than violent abuse. Explicit Islamophobic content was posted on the internet and sent via e-mails and text messages. In addition messages were left on cars and anonymous mail was sent to mosques, private homes and Islamic cultural centres. Particular prejudices were prominent within the borders of individual European states. A person's visual identity as a Muslim, particularly the wearing of the *hijab* by women, increased the chances of them being attacked. Similarly Sikh men wearing turbans were incidental targets because of a perceived resemblance to Osama Bin Laden.

Several factors have been cited to account for the rise of Islamophobia. The September 11 attacks with significant loss of innocent lives (BENN & JAYWAD 2004), and the London bombings in 2005 reinforced the view that Islam was militant and violent. BAR TAR and LABIN (2001) argued that short term national events could significantly alter racial stereotypes. It is known that a major world event caused by one group can influence perceptions of other social groups. In a UK study of seven ethnic groups, Pakistanis and Bangladeshis, who were primarily Muslim, reported the greatest increase between pre- and post-event discrimination post September 11 2001 (SHERIDAN & GILLETT 2005). Finally anti Muslim sentiments have swelled as part of a greater xenophobia as many white non-Muslims object to changes in "their" schools, public policies and social services in order to accommodate the perceived "inferior" needs of "outsiders". As Muslims are given greater recognition in the public sphere, so Islamophobic tendencies may amplify (VERTOVEC 2002).

Islamophobia and mental health

So what are the implications of this phenomenon for the mental health of Muslims? There is emerging evidence that discrimination, perceived discrimination and racism are linked to poorer mental health outcomes. This includes not only overt and institutional racism but also more subtle and indirect forms of discrimination. Workplace discrimination and chronic daily hassles including insults can increase the risk of common mental disorders (BHUI *et al*. 2005).

Although much academic literature has addressed racism, religious discrimination has largely been ignored. Few studies have explored the impact of Islamophobia on the mental health of Muslims in Britain post September 11. Sheridan investigated levels of self reported racial and religious discrimination in a sample of 222 British Muslims (SHERIDAN 2006). Respondents indicated that following September 11th, 2001, levels of implicit or indirect discrimination rose by 82.6% and experiences of overt discrimination by 76.3%. A significant relationship was found between racially motivated incidents and poor mental health (measured by GHQ) among Muslims in Britain. In this study 35.6% of participants suffered from mental health problems with significant associations between problem indicative scores and reports of experiencing specific abusive incidents of September11 related abuse by respondents. In this study minor incidents were much more common than extreme incidents of violence.

The *Muslim News* (26 October 2007) cited findings by the leading national mental health charity, Rethink, which indicated that Muslims in Birmingham with mental health problems had been prone to discrimination than their non-Muslim counterparts. Nearly two thirds of participants felt that the current perception and media coverage of Muslims was affecting their mental health. The Count Me in Census (Mental Health Act Commission 2008) which monitors the religious affiliation of patients admitted to psychiatric wards found an increase in the percentage of Muslims admitted to psychiatric wards in England and Wales from 3% in 2005 to 3.5% in 2007, mainly composed of Pakistani and Bangladeshi men. Unfortunately, the census does not date back to before 9/11. Additionally, due to factors such as stigma and a religious model of understanding mental illness, Muslims may not present to their GP or a psychiatrist for psychological or psychiatric problems, except at times of crisis. Therefore in order to quantify the impact of the Islamophobia on mental health, we would need to explore this amongst community samples of Muslims in the UK.

It is important to note that whilst Islamophobia is likely to increase the psychiatric morbidity of Muslims, there are other factors which are protective, for instance the strong sense of identity amongst

followers of Islam, social cohesion, and community support.

Implications for psychiatric treatment and training

What are the implications of Islamophobia for mental health professionals? Like any form of racism, health professionals need to be aware of the complex links between racism and mental health generally. Issues of discrimination and racial abuse may significantly impact on the therapeutic relationship between a white non–Muslim psychiatrist and a Muslim patient and may necessitate exploration in therapy. We do not however advocate here that Muslim patients necessarily consult Muslim mental health professionals nor that there should be specialised services for Muslim patients (Bhui, Bhugra & McKenzie 2000). Instead we recommend 'sensitive' services that are open to the needs of Muslim patients including issues of Islamophobia. Additionally, mental health research should also be more deliberately linked to clinical needs generally and in particular, with those related to racism (Bhui 2002). More specifically there is an urgent need for research addressing the mental health implications of Islamophobia.

Whilst there has been an apparent increase in the attention given to cultural issues in the psychiatric curriculum, the predominant approach has been to teach doctors (and other mental health professionals) 'cook book' lists of the customs of various cultural and religious groups. Both the Muslim Council of Britain and the Council on American-Islamic Relations have produced particularly thoughtful guides to providing culturally competent care for Muslim patients. Although this approach has some practical value, it ignores the wider issues of racism and discrimination. As Sashidharan argues, until we begin to address racism within psychiatry, in its knowledge base, its historical and cultural roots and within its practices and procedures, we are unlikely to achieve significant progress in improving services for minority ethnic groups (Sashidharan 2001). Health professionals would need to become more sensitive to issues of discrimination at diverse levels: individual, organisational and institutional. In addition to developing cultural sensitivity, psychiatrists should become sensitive to the religious and spiritual needs of patients. As Hope (2004) cogently argued, respect for diversity requires practitioners to understand and acknowledge diversity, and to comprehend the impact of prejudice on mental health and other services. Although these are commendable recommendations, to date they have been scarcely touched upon in psychiatric teaching or practice. We would concur with Sheridan (2006) that the dearth of empirical work on religious discrimination and mental health is a significant cause for concern.

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Simon Dein, PhD, FRCPsych, is Senior Lecturer in Anthropology and Medicine at University College London and a Visiting Professor in Psychology at Glyndŵr University, Wales. He has written extensively on millennialism and religion and health. He teaches an MSC in Culture and Health at University College London and is the editor of the international journal *Mental Health, Religion and Culture*. . (Conflict of Interest: SD is the Secretary of the Spirituality Special Interest Group of the Royal College of Psychiatrists. He holds an ESRC grant to examine the mental health of Bangladeshi Muslims in London.)

Department of Mental Health Sciences, University College London, Charles Bell House
67 Riding House Street • London WC1 7EY
Phone 020 7679 9435 • Fax 020 7679 9028
e-mail s.dein@ucl.ac.uk

Kalpana Dein, MRCPsych, MSc (Psychiatric Research) is a Consultant Forensic Psychiatrist in St Andrew's Hospital Basildon, Essex University. She has written on Aspergers and offending and sexuality and forensic psychiatry.

Clare House, Poundlane,
North Benfleet, Essex SS12 9JP
e-mail: kalthomas@yahoo.co.uk