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Exploring an Islamically-Integrated Peer Support Model for Muslim Syrian Refugees

Kashmala Qasim & Michaela Hynie

Introduction

The rates of mental illness are on the rise globally, resulting in detrimental economic, health, and social outcomes (World Health Organization, 2018). For example, depression, one of the most common mental disorders, affects approximately 300 million people around the world (Pearce et al., 2015). Due to the stigma surrounding the treatment of mental health, it is estimated that only between 35-50% of individuals receive the help that they need, or receive poor quality of care from existing support systems (World Health Organization, 2018). There has been a renewed interest in the integration of culture, faith and spirituality when providing mental health support and several faith-based therapies, such as Religiously Integrated Cognitive Behavioural Therapy, have also been developed (Haque et al., 2016; Pearce et al., 2015; Pargament, 2007). A growing body of intervention literature suggests the effectiveness of explicitly integrating clients' spiritual and religious beliefs into psychotherapeutic settings, which in turn can make mental health treatment more accessible and acceptable (Abu-Raiya, 2015; Anderson et al., 2015; Hodge & Nadir, 2008; Keshavarzi & Haque, 2013).

In Europe and North America, the decade of the 2010's has been notable for the increased awareness of migration and asylum seekers, with many of these newcomers identified as being Muslim (Abdul Rahman Latif, 2018; Hynie, 2018). Although the current response to forced migration has been complex and often contentious, it has also increased the awareness of the need for culturally appropriate mental health services for newcomers who have experienced trauma and hardship prior to arriving, and who can continue to experience a large number of stressors upon arrival, including family separation, poverty, unemployment and discrimination (Hynie, 2018). This attention to Muslim newcomers has been paralleled by a

long overdue increase in our awareness of the mental health needs of other Muslim community members (Hamdan, 2008; Rassool, 2015). The Western framework of mental health and illness has historically been suspicious of religious belief. For example, Freud referred to religion as a form of delusion for the masses (Abu-Raya, 2014) and much of his psychoanalytic work is theorized within a secular worldview (Husain & Hodge, 2016). In psychology today there continues to be a skeptical attitude towards religion. Most mainstream North American psychologists describe themselves as materialists, with no belief of meaningful regard beyond this life (Hayes & Cowie, 2005), and negative attitudes towards religion are prevalent among North American mental health professionals. In a recent survey, Foskett, Mariott, and Wilson-Rudd (2004) found that 45% of mental health professionals felt that religion could lead to mental-health related problems, while evidence suggests both positive and negative impacts of spiritual and religious beliefs and practices on people's physical and mental well-being. These attitudes towards spirituality and religious belief is problematic for effective mental health support. These attitudes contribute to a reluctance among Muslims to seek formal mental health services (Amri & Bemak, 2012) and, among those who seek and/or receive services, reduces the effectiveness of the care received.

There is evidence that patients benefit from a consideration of their spiritual needs by mental health professionals in the therapeutic relationship as well as in therapeutic approaches (Weatherhead & Daiches, 2010). It has been well documented that ideals relating to individualism have tended to dominate Western models of counselling, with therapists focusing on concepts such as self-esteem, self-actualization, and being able to communicate openly about one's opinions (Husain & Hodge, 2016). These ideals may be at odds with the basic tenets

of Islamic teachings, which tend to emphasize interdependence, community-actualization, self-control, delayed gratification and implicit forms of communication that safeguard others' feelings (Williams, 2005). The misalignment of Eurocentric therapeutic approaches with Islamic beliefs and teachings can further inhibit the effectiveness of counseling with Muslim clients.

Therefore, the goals of this chapter are to understand the role of religion, particularly Islam, in the Western framework of mental health and recovery, as well as to describe the ways in which traditional Islamic teachings are being applied within informal mental health support systems, including the role of *Imams*, and how Islamic principles can be used to develop formal models of therapy. Finally, we will be exploring a peer support model for Muslim refugees, particularly in the Canadian context and making recommendations drawing from the five pillars of Islam. Although the focus of this chapter will be Canada and Canadian Muslim communities, and the intervention we are proposing is one for Muslim refugees, we believe that there are common issues in this work that may be relevant to other Muslim communities around the world.

Fundamental Principles of Islamic Thought

Islam is the fastest growing religion in the world due to immigration, high fertility rates, and conversions (Nagra, 2011). There are about 940,000 Muslims living in Canada, and this number is estimated to rise to 2.7 million by 2030 (Hamdani, 2015). Muslim communities display a wide range of identities in terms of race, ethnicity, sectarian affiliation, class, gender, degree of religiosity, and generational experiences. The largest Muslim communities in Canada, by ethnicity, are South Asian (36 percent) and Arab (21 percent); however, there are also significant West Asian (e.g., Persian), Sub-Saharan African, and Southeast Asian Muslim

communities (Rahnema, 2008). By no measure are Muslim Canadians a homogenous community and any study focusing on religious identity must be mindful of the diversity and divisions among Muslims. Nonetheless, Islam has some core beliefs that are shared across communities.

Islam is a monotheistic religion, and is considered a way of life offering guidance within both the public and private spheres. Muslim children are taught from an early age about the five pillars of Islam (*arkan al-Islam)*, which are the foundation of Islamic ontology (Husain & Hodge, 2016). The pillars are categorized in the following *hadith*, or statement from the Prophet Muhammad: "Islam is built upon five [pillars]: testifying that there is none worthy of worship except Allah and that Muhammad is the Messenger of Allah, establishing the prayers, giving *zakat*, making pilgrimage to the House and fasting the month of Ramadan" (Bukhari and Muslim). The five pillars outline a framework for daily worship and are seen by Muslims, as a sign of commitment to their faith (Oxford Dictionary of Islam, 2019).

The first pillar, the *shahadah*, is comprised of two declarations: 1. Stating that there is no God but Allah, and believing in God's Oneness (*tawhid*) as well as relying on God's help and decree, and 2. Declaring that Muhammad is the messenger of God, who embodied the message of the Qur'an and served as an example for humanity (Rothman, 2018). This testimony of faith also signifies conversion, or entrance of a believer into the Muslim community (*ummah*) (Oxford Dictionary of Islam, 2019).

Following from the verbal statement of stating the Oneness of God, this testimony of faith is carried out in everyday life by the next four pillars. With regards to the five daily prayers, Muslims are commanded through the Qur'an (the most sacred text in Islam and believed to be

the word of God) to establish the prayer at prescribed times, which includes before sunrise, at noon, in midafternoon, just after sunset, and in the late evening. The concept of *establishing* prayers also encompasses praying on time, being in a state of cleanliness (i.e. performing ritualistic washing before the prayer), praying in the direction of the *Kaabah* in Mecca, and being mindful of the physical actions and words that one is reciting throughout the prayer (Sheikh, 2018). The third pillar in Islam, *zakah* (alms tax), directs Muslims to donate 2.5 percent of their savings annually to those who are in need (Oxford Dictionary of Islam, 2019). The fourth pillar is fasting in Ramadan which corresponds to the ninth month of the lunar Islamic calendar. Muslims abstain from food, drink, and sexual activity from sunrise to sunset, in order to attain God consciousness as well as to develop empathy for those less fortunate (Quran 2:183). The final pillar is the pilgrimage to Mecca during the first ten days of the month of Dhu al-Hijjah. This trip is incumbent only upon those Muslims who are physically and financially capable.

The Qur'an and many of the Prophetic teachings also deal with and provide practical strategies for common psychosocial concerns and developmental milestones, such as marriage, legal rulings around divorce, financial transactions, taking care of elderly parents, child rearing, and adoption. Taking into account this Islamic framework, the daily and seasonal acts of worship serve as not only guidance, but may also be helpful for personality adjustment and mental health (Baasher, 2001). For example, in the month of Ramadan, Muslims are afforded the opportunity to develop good habits for the rest of the year, and abstain from harmful ones, such as alcohol or drug addiction (Baasher, 2001). These Islamic directives also conceptualize hardships in life, such as illness or loss of a loved one, as trials from God through which a believer is purified, and if patient, will be rewarded in the Hereafter. Traumatic life events are

not seen as a punishment necessarily, since the Qur'an recounts several stories of Prophets who were afflicted with extreme illnesses or family situations. Therefore, Muslims view life's struggles as opportunities to grow, and believe that daily Islamic practices such as the five prayers and reciting the Qur'an, contribute to positive psychosocial health, both at the individual and community level (Baasher, 2001).

Theories of Islamic Psychology

Islamic psychology encompasses a framework regarding human thought, emotion, and behavior that originates from traditional Muslim thinkers, such as Abu Hamid Muhammad al-Ghazali, and Abu Zayd al-Balkhi, and how this knowledge interacts and even informs Western models of therapy (Keshavarzi & Khan, 2018; York Al-Karam, 2017). Islamically-integrated models of psychotherapy are embedded within this specific ontological and epistemological paradigm, which then guides practitioners' and researchers' understanding of health and pathology (Keshavarzi & Haque, 2013).

A number of Western therapeutic approaches are easily aligned with Islamic teachings and principles. Talk therapy, for example, has been a long part of the Islamic tradition (M. Badri, 2012, Trans.). In his book *Sustenance for Bodies and Souls*, Abu Zayd al-Balkhi, a prominent 9th century physician, described in detail various forms of therapies, including talk therapy, cognitive-based therapy and psychodynamic approaches (M. Badri, 2012, Trans.). Al-Balkhi described that an external form of nourishment is that one can listen to the advice of another "whose discussion would calm the agitated soul and treat its abnormality" (M. Badri, 2012, Trans.). In addition, he utilized many modern day clinical terms when explaining behavioural phenomena, such as symptoms, endogenous vs. exogenous causes of depression and

personality styles (M. Badri, 2012, Trans.). Nonetheless It is crucial to be sensitive to Muslim clients' faith-based worldviews, as well as their individual level of religiosity and spirituality. For example, in the case of practicing Muslims, one study found that there was greater receptivity to psychotherapy and an understanding that averse emotions are not a sign of weak faith when narrations from the Qu'ran and *Sunnah* (Prophetic teachings) were used in the therapeutic process (Asamarai, 2018).

Traditional models of Islamic counselling, are derived from the Qur'an, the Sunnah and literatures of Muslim scholars. Al-Ghazali is one of the earliest and prominent Islamic philosophers, describing human nature as an integration of bodily and spiritual forces. An individual's human nature is comprised of four elements, namely, the *Ruh* (spirit), *Aql* (cognition), and *Nafs* (tendencies). All three elements are an expression of the *Qalb* (heart) (Yaacob, 2013). He defined spiritual/psychological illness as distance from God and the degree of health as a function of the degree of that one experiences proximity to God. This means that the ability to function positively in everyday life does not equate to sound mental health but it is the development and presence of positive character traits, an important Islamic science called *tazkiyat-un-Nafs* (purification of the soul).

Al-Ghazali's approach has led to the creation of various models of Islamically integrated models of care, such as Islamic Cognitive Behaviour Therapy which includes cultivating close rapport with clients, identifying root causes of problems, combating desire, and exercising the soul (Zakaria & Akhir, 2017). Several other concepts have also been translated from the ideas of Al-Ghazali such as opposite therapy, contemplation, prayer, and the power of suggestion. The underlying principles for many of these techniques involves asking the client to separate

themselves from the materialistic world (*dunya*) and to contemplate their relationship with God. The process of contemplating is aimed at helping the individual to create a strong connection of the intellect (*aql*) with the heart (*qalb*) (Nik Rosila, 2013).

Similarly, Keshavarzi & Khan (2018) have described a model of Islamic psychotherapy, that includes five components, including the *aql* (cognition), *nafs* (behavioural inclination), *ruh* (spirit), *ihsaas* (emotion) and *qalb* (heart). The *nafs*, in its uncontrolled state is similar to the Freudian concept of the id, acting primarily on hedonistic desires. However, with refinement, the *nafs* can progress from a state of restlessness to being at peace, and find joy in virtuous behaviours such as praying (Keshavarzi & Khan, 2018). The *aql* is the likened to the brain, which is the rational faculty of a person. It possesses intelligence and acts from a place of logic (Keshavarzi & Khan, 2018). The *ruh* is the "spirit or life force of the human being, and has an affinity for the sacred, a thirst for meaning, and longing for the divine" (Keshavarzi & Khan, 2018). The *qalb* (heart) is at the center of this model, and both receives and provides feedback to the other components of the psyche. In a *hadith* (statement of Prophet Muhammad), the heart is described as something that changes more frequently than boiling water. It is important to note the dynamic nature of this model, in that all components are interrelated (Keshavarzi & Khan, 2018). For example, a behavioral addiction, such as alcohol abuse, can lead to dysfunctional thinking, as well as incorrect beliefs about God's mercy for example, leading to a decrease in spirituality (i.e. a prayer cannot be performed in the state of drunkenness) and then finally resulting in a "darkness" over the heart (Keshavarzi & Khan, 2018).

Mirdal (2010) shares principles of mindfulness in the teachings of Jalal-ud-Din Muhammad Rumi. Analyzing Rumi's works of the *Masanavi* gives insight into the journey of

human soul and its connection to a divine essence through freedom from the suffering of the worldly vanity. For Rumi, the soul is like a pure child and society seen as a destructive community that attacks through inductions, temptations, and suggestions, which the soul is compelled to yield to after resisting. The main cause of mental illness, in this framing, is moving away from the ego principle, which is divine and pure natured (Hakimi & Hakimi, 2018). It can be extracted from the works of Rumi that mental illness is also caused by cognitive distortions, which lead to a failure of stability and feelings of worthlessness, symptoms of depression. Mirdal thus proposes an approach to mindfulness that entails acceptance and acknowledgement of both positive and negative experiences; unlearning of old habits and looking at the world with new eyes; and decentering, changing one's focus from self to other. In this we can see both traditional practices of mindfulness but also expressions of traditional Islamic beliefs about mental health.

Despite the several advances in Islamically informed therapies, to the best of our knowledge, there is yet to be a single, unified Islamic model of psychology or a theory of Muslim mental health (Rothman & Coyle, 2018). There is consensus however on the following theoretical concepts: 1. The *fitrah* (human soul) is born pure, is innately good natured and is inclined towards an upward trajectory of knowing God, 2. The *fitrah* becomes forgotten and "rusted" as part of a normal life course, 3. Remembering God and doing good works can help to align the soul with the *fitrah*, whereas negative characteristics and following undesirable impulses can result in a state of heedlessness of others and of God (Rothman & Coyle, 2018).

Thus, the goals of an Islamically informed model of mental health care would be to assist individuals in uncovering the *fitrah*, by using emotional, cognitive and behavioural

techniques from the Qu'ran and *Sunnah* in order to achieve God's pleasure in this world and the Hereafter. Because Islam views the self as a dynamic spiritual being within a collectivistic framework, Muslims may be influenced by their social support system which may then shape their attitudes towards mental health problems and recovery (Rassool, 2015; Rothman & Coyle, 2018).

Social Support in Faith-Based Communities

Social support can be separated into *perceived* social support and *received* social support (Hynie, 2015). Perceived social support is the extent to which individuals *perceive* that emotional, informational or material support is available when needed. Received social support refers to the actual support enacted and received, such as financial assistance (Cohen, 2004). It is perceived support that appears to have the strongest links to psychological well-being (Lakey & Orehek, 2011). It is important to note that seeking out social support did not have a practical or direct impact on participant's wellbeing. Several studies suggest that during stressful times, individuals tend to form social networks through which they are able to discuss challenges, and receive and provide feedback, as well as material resources (Carver & Connor-Smith, 2010). There is also evidence to suggest that strengthening social support from network members without providing formal counselling may be sufficient to reduce the severity of postnatal depression, at least in some contexts (Hynie et al., 2016).

For many individuals, informal social networks include religious community leaders which may be the first line responders for mental health care. This may be particularly true in the Muslim community. Rassool (2000) found that Muslims perceive their life stressors as a test

of one's faith. Therefore, Muslims often seek guidance from Imams, and are a crucial part in playing a role in shaping family and community attitudes regarding mental health (Padela, Gunter, Killawi & Heisler, 2012). Imams also play a facilitator role by helping communities gain access to a larger network of mental health services (Ali & Milstein, 2012). We have found in our work, that Imams are perceived to be very accessible by the community, as many Imams will hold office hours after specific prayers of the day, usually in the Mosque (Qasim & Hynie, 2018). Additionally, Imams do not charge a fee for these one on one consultations, thereby, encouraging their congregation to approach them for faith-based counselling services (Qasim & Hynie, 2018). Among Muslims who do reach out for help to Imams, the majority seek counsel over marital and family issues (Ali et al. 2009; Ciftci et al. 2013; Qasim & Hynie, 2018; Rassool, 2015).

Abu-Ras, Gheith & Cournos (2008) found that 94% of mosque attendees from 22 mosques in New York City perceived their Imam as a counselor, and 97% of participants found Imams to be a source of religious guidance. Moreover, studies suggest that Imams spend significant time "counseling" congregants. A study of 56 Imams reported that half of the Imams spent one to five hours a week in counseling activities, and 30% of Imams spent six to ten hours a week (Ali, Milstein, & Marzuk, 2005). However, Khan (2006) reported that although more than half of the Muslims in the study had pro-counseling attitudes, 45.5% of the participants reported never seeking comfort from an Imam. Moreover, despite the Imams' commitment to social work activities and their acceptance as a source of guidance, many Muslims feel that Imams are lacking training to provide an adequate level of support (Ciftci, Jones, & Corrigan, 2013).

Despite being highly qualified in Islamic sciences and theology, Imams themselves have reported a lack of formal counselling training and tended to utilize a combination of informal psychotherapeutic techniques based on Islamic teachings (Abu-Ras et al., 2008; Khan, 2006; Qasim & Hynie, 2018; Sa'ad, Razali, Sanip, & Mohd Rani, 2017). Interestingly, Ali & Milstein (2012) reported that there was a positive correlation between an Imam's willingness to counsel an individual and collaborate with a clinician to the amount of training he's received. Imams who did not report any experience with pastoral counseling or Western psychotherapy, also reported they found great difficulties in differentiating signs of various mental illnesses (Abu-Ras et al., 2008).

There is very little psychological research addressing the attitudes and perceptions of Canadian-Muslims towards help-seeking behaviour and thus research on culturally relevant tools, resources and practices in addressing mental health issues in the Canadian-Muslim community is scarce (Ali et al. 2009). Therefore, it is important to consider the role of faith in coping, especially in the rising Muslim refugee community globally and in Canada (Abdul Rahman Latif, 2018).

The Role of Faith and Coping in Refugees

Refugees are individuals who have crossed international borders as a result of a "well-founded fear of being persecuted" on the basis of their religious, political, sexual, or other social identity, and whose country will not or cannot protect them or may in fact placing them in danger of persecution (Hynie, 2018). The number of refugees has been increasing since the last few decades, with 65.6 million people reported as living under forced displacement in 2016 (Abdul Rahman Latif, 2018; Hynie, 2018). The resettlement and integration process is

challenging for all newcomers, however, refugees as compared with voluntary migrants, present several challenges, such as undergoing or witnessing torture, poorer health outcomes, fewer economic prospects, and limited social networks, all of which create a unique sense of vulnerability (Hynie, 2018; El-Khani, Ulph, Peters & Calam, 2017; Picot, Hou, & Coulombe, 2008).

Prior to the revolution, Syria was the third largest refugee hosting country, accommodating refugees primarily from Palestine. However, with the recent conflict, it has turned into the largest refugee producing country (UNCHR, 2013). Before the conflict, Syria was home to 22 million people (Kahf, 2013). The Syrian population consists primarily of three religious groups: Muslims (87%), Christians (10%), and Druze as well individuals from the Jewish faith (3%) (UNCHR, 2013). Since 2011, more than 12 million people from Syria have been impacted through forced migration and displacement, and represented in the media as the "Syrian Refugee Crisis". Canada has seen the arrival of more than 40 000 Syrian refugees and as part of this Syrian experience (IRCC, 2017), it is particularly important to understand which coping mechanisms Syrian men and women are utilizing to navigate the various financial, psychological and cultural stressors, as they resettle into a new country (Alzoubi, Al-Smadi, & Gougazeh, 2017).

Pargament (1997) defined coping as a "search for significance in times of stress" (Xu, 2016). Faith-based coping mechanisms are "ways of understanding and dealing with negative life events that are related to the sacred" (Pargament et al., 2000). According to Pargament, religious coping serves several objectives including, to uncover meaning in a situation, to gain a

sense of control, to achieve peace through feeling closeness to God, to develop connections with others, as well as to have a transformative life experience. According to this definition, religious based coping provides a buffer against increasing stressors by placing trust in a higher power, as well as contributing to a more compassionate worldview especially in times of injustice and oppression, such as in the Syrian refugee experience (Ai, Peterson, & Huang, 2009). Religious belief systems play a crucial role in the coping process (Alzoubi et al., 2017). Several studies indicate that trusting and believing in a just and merciful God is a common religious coping strategy amongst Muslims (Alzoubi et al., 2017; El-Khani et al., 2017). Furthermore, refugees arriving from countries with higher levels of communal religiosity tended to adhere more strictly to religious rulings as a coping mechanism while adjusting to a new culture and self-identity (Buber-Ennser, Goujon, Kohlenberger & Rengs, 2018). For example, within a Somalian and Ethiopian sample, upwards of 75% of refugees utilized prayer to cope with sadness (Khawaja et al., 2008). Faith was also used by Syrian parents residing in camps (El-Khani et al., 2017). The participants reported submission to God, and reciting the Qu'ran as a mechanism to soothe themselves, as well as to provide hope and a forward-looking approach to the Hereafter (El-Khani et al., 2017). Finally, religion, and faith-based institutions may also be a source of social support. For example, Muslim Syrian refugees in Toronto reported looking to the Mosque for "complicated" help, which included instrumental support, spiritual guidance as well as a common meeting point to share resources with the community (Qasim, Hynie, & Greenglass, 2018). El-Khani et al. (2017) also reported that social support for Syrian refugee parents allowed them to seek help from with other parents, on the various

challenges of raising children while residing in camps by normalizing their thoughts and behaviours.

There is a tendency, however, to confound personal faith and religion. It is important to recognize that these can be separated into institutional religion, which includes the rituals, relationships, norms, beliefs, and structures of a particular religion, and personal beliefs. With this in mind, researchers have recently validated a scale of Spiritual Personality, which looks at two dimensions of individual differences, including how Muslims approach Islamic knowledge (experience vs. judgment) and disposition to behavior (action vs. restraint) (Abdul-Rahman & Khan, 2018). When working with Muslims who may be struggling with understanding their individual orientation to spirituality and their connection with God, encouragement from Qur'anic verses such as: "*Everyone behaves according to their nature (shākil)"* may be an excellent starting point (*Surah Isra*, 111).

A faith-based approach would also take into account how individual differences can make for certain Islamic moral (*akhlāq*) qualities easier or harder to obtain. For example, a person who is low on the personality trait of neuroticism, which is associated with higher levels of emotional stability, may find it easier to adopt an optimistic attitude, an *akhlāq* trait (Abdul-Rahman & Khan, 2018). Someone who is more introverted may find introspection and reflection (*murāqaba*) easier whereas an extroverted individual may find it easier to maintain ties with family and friends (*silat ar-rahim*) as a way to offering and seeking social support (Abdul-Rahman & Khan, 2018).

In contrast to seeking social support, avoidant coping is defined as the cognitions and behaviours that are used to reduce the negative effects of a challenging situation, for example by ignoring or deferring (Afshar et al., 2015). Within the avoidance coping style, studies indicate that refugees may turn to negative forms of coping, such as alcohol and drug abuse, smoking, and gender-based violence, especially as a means to cope with daily stressful conditions (Daud, 2009). Additionally, refugee participants have reported several ineffective coping strategies, such as sleeping, distraction, and social withdrawal (Finklestein et al., 2012). In terms of using religion in a negative context, evidence suggests that individuals may adopt dooms-day type beliefs about their life situation, take on a more literalist interpretation of sacred texts, as well as rely solely on prayer without receiving or providing any instrumental support (Ano & Vasconcelles, 2004). Harmful ways of coping have also been linked to several physical health conditions, including, headache, fatigue, hypertension, and diabetes mellitus (Khawaja et al., 2008). For example, in one study, refugees residing in camps have reported adopting harmful and passive coping strategies, such as avoiding their present circumstances, and cognitively framing their condition as out of one's control (Alzoubi et al., 2017). Therefore, it is critical when working with individuals within a faith-based framework, to assess any maladaptive forms of coping, such as avoiding and passivity, especially if its emerging from a dogmatic belief system.

Overall, it may be beneficial for researchers, clinicians, and front-line workers to understand the pathways of developing social networks, that are conducive to certain coping styles, and to provide therapeutic assistance to those individuals that are prone to using maladaptive coping mechanisms. Additionally, when working with faith-based communities,

such as the Muslim community that values interdependence and a religious worldview, it is crucial to utilize culturally appropriate models of care within an existing social support system (Keshavarzi & Khan, 2018).

Islamically Integrated Model of Peer Support

We have thus far outlined the various types of coping mechanisms that individuals utilize, including the role of faith, as well as the importance of social support in Muslim refugee communities. One promising community-based model of social support includes the use of peer support. Peer support is defined as social, emotional and instrumental support, that is provided in either in a formal or informal setting (Solomon, 2004). The peers are individuals in the community that have lived experiences of the target concern, and have also undergone the recovery process (Pound, Judd, & Gough, 2011; Solomon, 2004). Peer groups are not as formal as psychiatric care, nor are they just about being friends (Pound et al., 2004). In a peer support model, individuals operate in a reciprocal, respectful and non-linear approach of providing and receiving help, in order to change problematic thoughts, behaviours and coming out of "stuck" places (Hurlock 2010).

There are several features of peer support, that make it a unique form of social support and therapy. This includes for example, uniting members of a group together to discuss a common issue. Secondly, peer support groups are facilitated by another member of the community, who has undergone a challenge as well as the recovery process, through which he/she can provide hope and motivation for others going through similar challenges. Additionally, it is theorized that social support could decrease the use of harmful coping strategies such as avoidance as

individuals believe their social network includes someone who will be available to listen (Tao et al., 2005).

Interestingly, the principles underlying peer support are similar to the ones taught in psychotherapy for individual counselling (Solomon, 2004). This includes empathy, creating a safe space, non-judgmental attitude and use of validation. In contrast to the therapist-client relationship, peer support models utilize a facilitator who has undergone an experience related to mental health, and also the recovery process, therefore, there are elements of hope, empowerment and healing present in peer support groups (Solomon, 2004).

Researchers have identified that Islam plays a crucial role in the lives of Muslims, therefore, it would be beneficial to not only include a component of spirituality but to frame a peer support model using an Islamic lens, depending on the facilitator's assessment of the group's level and connection of spirituality (Sheikh, 2018). The peer support model, based in the Muslim refugee community, can build upon the community members' resiliency, and how "hope and trust are reconstructed through an increased awareness of how socio-political forces have created oppression, and this hope can then allow for the building of trust and connection between community members" (Hynie et al., 2015). In addition, when working within a peer support framework, clinicians have found it useful to share Prophet Muhammad's saying, "A believer is the mirror of a fellow believer" (Al-Adab Al-Mufrad 12:238). Through sharing this *hadith* at the outset of a session, clients and peers alike, may be encouraged to take a non-judgmental position and reflect on the idea of a mirror, which by definition displays what it is shown (Asamarai, 2018). Taking the mirror analogy further, the peer group can organically

allow for change without undue pressure, or harshness, by simply reflecting and drawing attention to processes as they happen (Asamarai, 2018).

The aforementioned pillars of Islam can also be drawn from to explore a faith-based model of peer support. For example, the first pillar represents a set of beliefs about one's relationship with God and this would ideally be the starting point in an Islamically integrated peer support group. Qualitatively, everyone's relationship with God will look different, however, a safe group environment will allow participants to reflect on concepts integral to the Islamic creed, such as *tawhid* (Oneness of God), *tawakkul* (trusting in the plan and decisions of God) and the prohibition of *shirk* (associating anyone in the attributes of God). These conversations can be guided by the facilitator to understand how participants' use their faith to navigate emotions in their everyday lives, as well as how they use their connection with God to cope with suffering and loss.

The mindful component of *salah* (prayer), the second pillar of Islam, can be translated into a peer support setting. Mindfulness practice is defined as "a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations (Parrott, 2017). During prayer, Muslims are encouraged to envision their relationship with God, and to be in a state of heightened awareness that God is watching over them. For example, in one study, participants who were more knowledgeable about *Salah* tended to be more mindful in their prayer (Ijax, Khalily & Ahmad, 2017). Studies have also indicated that offering the daily prayers regularly was associated with positive mental health outcomes (Ijax, Khalily & Ahmad, 2017). An Islamically integrated peer model can utilize this fundamental tenet of Islam, and perhaps utilize the

various prayer positions (i.e. reflecting while in a state of prostration instead of sitting on chairs) and reflect on the verses in the Qur'an that highlight the benefits of prayer as ''satisfaction for heart'' (*Ar-Ra'd:*28) and a "source of keeping a person away from wrong behaviour'' (*Al-'Ankabut*:45).

Additionally, the principles underlying *zakat* or mandatory charity, can be utilized as a framework for community building as well as capacity building amongst the peers. *Zakah* in essence, serves as a reminder of one's broader social responsibilities to the community by helping those who are in need and strengthening the ties of brotherhood and sisterhood (Sheikh, 2018).

Conclusion

In summary, Islamic teachings highlight a collectivistic, community-based approach to health and spirituality, rather than an individualistic one (Husain and Ross-Sheriff, 2011). A statement by Ibn Khaldun, a North African historian and scholar from the 14th century truly captured this ideology by stating that "compassion and affection for one's blood relations and relatives exist in human nature as a divine gift put into hearts of men. It makes for mutual support and aid" (Katsiaficas, 2014). Keeping this in mind, an Islamically-integrated peer support group might be more beneficial than traditional therapy or counselling, as it utilizes natural social support already available at Mosques and Islamic classes for children, especially for Muslim refugee families. Furthermore, an Islamically-integrated peer support model allows for reflections about the group's relationship with *Allah* (God), as well as an assessment of the

aforementioned internal domains of each individual's psyche (*nafs, aql, ihsaas, ruh, and qalb*) as it relates to their narrative of displacement, resettlement and forced migration.

Within Islamic law, Muslims are held responsible for maintaining respectful ties with their families, neighbors and the community at large, therefore, an Islamically-integrated model of peer support can be likened to worship (as well as create a buy-in from community leaders) in actualizing a commandment of God. Finally, the facilitator working from an Islamic paradigm, would ideally hold a humble position in that the individual will understand that he/she is simply an instrument of *Allah* (God) and a means to achieving recovery and healing, as is stated in the Qur'an: "And when I am ill, it is He (God) who cures me" [26:80] (Rüschoff & Kaplick, 2018).

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