CHICAGO THEOLOGICAL SEMINARY

ADDICTION IN THE MUSLIM COMMUNITIES IN THE UNITED STATES: TOWARDS A MOSQUE-BASED MANUAL FOR PREVENTION, SUPPORT, AND REFERRAL

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BY SHAZIA ASLAM, M.D

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Dedicated to my late father, Ale Nabi Khan, an avid reader and an excellent writer. I miss your advice and presence. To my mother, Iqbal Begum, for all her love and prayers.

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GLOSSARY

Acculturation Stress- Psychological strain experienced when individuals attempt to adapt to a different cultural environment.

Addiction- A chronic condition characterized by compulsive substance use or behaviors despite harmful consequences.

Behavioral Addiction - Compulsive engagement in behaviors such as gambling, gaming, or pornography that interfere with normal functioning.

Biopsychosocial Model - A framework explaining addiction through the interaction of biological, psychological, and social factors.

Brain Disease Model of Addiction -A scientific model describing addiction as changes in brain reward pathways and decision-making systems.

Dhikr - Remembrance of God through prayer or repeated recitation in Islamic spiritual practice.

Dopamine Reward System - A brain pathway responsible for pleasure and motivation that is altered by addictive substances.

Fitrah - The innate human disposition toward faith and moral awareness in Islamic theology.

Ḥifẓ al-ʿAql- The preservation of intellect, one of the higher objectives of Islamic law.

Imam - A Muslim religious leader who provides spiritual guidance and community leadership.

Islamophobia - Prejudice or discrimination directed toward Muslims.

KhamR- An Arabic term referring to intoxicants that impair the intellect and are prohibited in Islam.

Maqāṣid al-Sharīʿah - The higher objectives of Islamic law aimed at protecting essential aspects of human well-being.

Mixed-Methods Research - A research approach combining quantitative data (surveys) with qualitative data (interviews).

Mosque-Based Intervention - Community initiatives within mosques that provide education, prevention, and referral support for addiction.

Nafs - The inner self in Islamic psychology associated with desires and impulses.

Qiyās - Analogical reasoning used in Islamic jurisprudence to extend legal rulings to new circumstances.

Rahma (رحمة) - An Arabic term meaning mercy and compassion, a central ethical principle in Islam.

Sabr - Patience and perseverance during hardship in Islamic spiritual teachings.

Sharīʿah- - The moral and legal framework derived from the Qur'an and prophetic traditions.

Stigma -Negative social attitudes that lead to shame and discourage individuals from seeking help.

Substance Use Disorder (SUD)-A clinical diagnosis describing problematic substance use causing impairment or distress.

Sutra-A cultural concept referring to privacy or covering personal matters to preserve dignity.

Tawbah- Repentance and returning to God after wrongdoing.

Tawḥīd- The Islamic belief in the oneness of God.

T**awakkul-** Trust and reliance upon God while making responsible efforts.

Tazkiyat al-Nafs - The purification and spiritual development of the soul.

Treatment Gap -The difference between individuals who need addiction treatment and those who receive it.

ʿ**Ayb** - A cultural concept referring to shame or social dishonor within a community.

ABSTRACT

Author: Aslam, Shazia, M.D

Institution: Chicago Theological Seminary

Degree Received: Doctor of Ministry

Title: Addiction in the Muslim Communities in the United States: Towards a Mosque-Based Manual for Prevention, Support, and Referral

Supervising Professor: Dr. Jibril Latif

Rahma (رحـــمة): the Arabic term derives from the root r-h-m, conveys the meaning of mercy, compassion, tenderness, and care towards each other. This is one of the attributes of God Almighty: Al Rahman, Al- Rahim—emphasizing mercy as a central ethical principle in Islam. It is repeatedly reminded in the Quran and prophetic tradition to show mercy to others.. Yet within many muslim communities, addiction and substance use disorder remain hidden beneath layers of silence, shame, and stigma due to fear of being judged. This raises a question: if mercy is the core value of one's faith, then why are individuals struggling with faith hesitant to seek help within their community? Through my thesis, I explore how addiction is perceived and addressed in the Muslim community, and the role of mosques in support and prevention.

After reviewing the literature, I researched the Minnesota Muslim community on how addiction is perceived and addressed. What are the realities in my own neighborhood? What roles can mosques play in addressing it with culturally sensitive education for prevention, and

what are the resources available as community institutions for prevention, support, and referral?

For the purpose of collecting data, I used a mixed-method approach, which combines a literature review. To collect data, interview, and survey responses collected from members of Muslim communities in Minnesota. Interviews were conducted with a combination of clinicians, an addiction medicine specialist, an Imam, a community leader, and an individual involved in recovery work. An anonymous survey was distributed through a community network online to gather a broader perspective regarding addiction awareness, stigma, and help-seeking behaviors.

The findings indicate that addiction does exist within Muslim communities. The least answered question was when participants were asked about the type of drugs they personally or someone they know experienced, got the least response, 74 out of 94. Addiction often remains concealed due to secrecy, stigma, fear of judgment, and concerns about family and community reputation. Participants described how families frequently attempt to manage addiction privately and may delay seeking professional help until the situation becomes severe.

The study highlights that mosques remain a trusted institution, but participants also express that mosques are not ready to play an important role in reducing stigma, increasing education, and guiding individuals towards appropriate resources. The project concluded by proposing a mosque-based framework that encourages collaboration between religious leaders, healthcare professionals, and community organizations to promote prevention, compassionate support, and pathways toward recovery.

CHAPTER 1:

INTRODUCTION

1.1 Context of the Problem

Addiction remains one of the most challenging and complex public health domains in the United States, affecting millions of individuals across different socioeconomic, racial, and religious communities. It has many aspects, such as alcohol use disorder, opioid dependence, misuse of prescription medications, and behavioral addictions. These conditions continue to affect millions of Americans, impacting family systems, straining healthcare resources, and challenging communities. Across the globe and within the United States, national health data show that substance use disorders not only contribute significantly to morbidity and mortality but also affect social stability[1](World Health Organization 2018; SAMHSA 2023). Addiction can take multiple forms. While substance-related addictions, such as alcohol, opioids, and prescription drug misuse, are most commonly discussed in public health literature, behavioral addictions such as gambling, pornography use, gaming, and internet dependency are increasingly recognized as significant concerns.[2]

In many religious communities, including Muslim communities, behavioral addictions may be more difficult to detect because they are often hidden and rarely discussed openly. As a result, individuals struggling with these forms of addiction may remain unnoticed for long

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[1].World Health Organization, *Global Status Report on Alcohol and Health* (Geneva: World Health Organization, 2018), https://www.who.int/publications/i/item/9789241565639; Substance Abuse and Mental Health Services;
Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health 2023* (Rockville, MD: U.S. Department of Health and Human Services, 2023),

[2] SAMHSA, *National Survey on Drug and Health 2023*

periods of time. Faith communities face unique challenges, and in many of these communities, addiction remains inadequately addressed, misunderstood, and deeply stigmatized due to social and religious contexts. Religious traditions often provide moral guidance, social support, and meaning-making frameworks that can protect individuals from harmful behaviors.[3] At the same time, when addiction is framed solely as a moral failure or spiritual weakness, communities may unintentionally reinforce shame, silence, and exclusion. Research on religion and recovery also suggests that faith communities can play a positive role in supporting individuals seeking recovery when compassion, education, and community support are present.[4]

1.2 Addiction and Stigma in the Muslim Community

The contradiction between religious belief and lived realities creates a unique pastoral and public ministry challenge. Islamic teachings clearly prohibit intoxicants (khamr), and abstinence from alcohol and drugs, refraining from non-permitted sexual behaviors are widely viewed as a marker of religious commitment. When addiction in Muslim communities is viewed as a spiritual weakness, moral or parental failure, rather than a complex biopsychosocial condition, an individual struggling with addiction faces intense stigma, fear of exposure, and concern about losing religious or social standing. Stigma plays a central role in shaping Muslims' response to addiction. Research studies consistently reveal data that fear of judgment, loss of honor, and concerns about confidentiality are major barriers to seeking care.[5] Addiction is 2

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[3] Harold G. Koenig, "Research on Religion, Spirituality, and Mental Health: A Review," *Canadian Journal of Psychiatry* 54, no. 5 (2009): 283–291, https://doi.org/10.1177/070674370905400502; Kenneth I. Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice* (New York: Guilford Press, 1997).

[4] Brian J.Grim and Melissa E. Grim, "Belief, Behavior, and Belonging: How Faith Is Indispensable in Preventing and Recovering from Substance Abuse." *Journal of Religion and Health* 58, no. 5 (2019): 1713–1750.

[5] Sameera Ahmed and David Doukas. "Muslim American Youth and Substance Use." *Journal of Muslim Mental Health* 10, no. 1 (2016), https://quod.lib.umich.edu/j/jmmh/10381607.0010.101

commonly perceived as a violation of Islamic beliefs rather than as a health condition requiring a compassionate approach and understanding, and for effective treatment.

Data on substance use disorder(SUD) among Muslim Americans is still an emerging field; newer research suggests a more complex reality. Studies indicate that Muslims living in the United States are not immune to substance use disorders. Ahmed and Doukas (2016) found that approximately 10.9%of Muslims in the United States reported a lifetime alcohol or drug use disorder, while nicotine dependence was reported at even higher rates.[6] (Ahmed and Doukas 2016). Other studies focusing on Muslim youth and young adults suggest that substance use may occur regardless of religious identification, often in hidden or isolated forms[7](Ahmed et al. 2014).

Despite the challenges in general perception and varying levels of religious affiliation, taboo against mental health and addiction in many Muslim cultures and communities, Islam is a communal religion; it emphasizes not only individual well-being but also the importance of family and community. Muslim communities uniquely possess significant protective resources, including strong family networks, spiritual practices, and mosque- centered social life. Islamic researchers and scholars believe that when appropriately mobilized, these resources can play a powerful role in prevention, recovery, and rehabilitation.

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[6] Ibid

[7] Sameera Ahmed, Mona Amer, and Joseph R. Tareen. "Substance Use among Muslim Youth." J*ournal of Muslim Mental Health* 8, no. 2 (2014)

1.3 Role of Imams and Mosques

The widespread assumption that addiction is not a Muslim issue is largely due to underreporting. Emerging data suggest that addiction exists. In many cases, individuals struggling with addiction may delay seeking help because of concerns about community perception.[8] When addiction is understood only through moral or spiritual language rather than as a biopsychosocial condition, individuals and families struggle to find appropriate support. Unfortunately, fear of social consequences may lead families to conceal addiction rather than seek professional help. These factors contribute to delayed treatment, worsening outcomes, and increased suffering for individuals and families.[9] These contradictions between religious ideals and lived realities also create a unique pastoral challenge. In addition, Muslim communities in the United States are diverse, including immigrants, second-generation Muslims, refugees, and converts from many cultural and socioeconomic backgrounds. While they share common religious principles, their experiences with addiction, mental health, and help-seeking behaviors may vary widely depending on cultural context, generational differences, and levels of religious engagement. Within this environment, mosques often serve as the central institution of community life. Beyond their religious role, mosques function as social spaces, educational centers, and community gathering places. Many individuals turn to imams and mosque leaders for guidance during personal crises, including marital issues, family conflicts, and mental health concerns.[10]

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[8] Ansary, Nadia S., and Alicia Salloum. "Muslim Americans and Mental Health: A Review of Challenges and Solutions." *Social Work in Public Health 2*8, no. 3–4 (2013): 396–412.

[9] Ansary and Salloum, "Muslim Americans and Mental Health", 396–412.

[10] Wahiba Abu- Ras, Saher Gheith, and Francine Cournos, "The Imam's Role in Mental Health Promotion: A Study of Imams in New York City." *Journal of Muslim Mental Health* 3, no. 2 (2008)

However, addiction presents a particularly difficult challenge for mosque leadership. While imams are often trusted figures within the community, they often lack formal training in addiction counseling, mental health assessment, or referral systems. Research suggests that imams frequently act as first responders when community members seek help for personal struggles. Yet many report limited preparation in addressing addiction or coordinating care with healthcare professionals. This gap can create uncertainty regarding confidentiality, boundaries, and appropriate interventions.[11]

As a result, mosques often respond to addiction only when a crisis occurs, rather than addressing the issue through prevention, education, and early intervention. This reactive approach reflects broader structural limitations rather than a lack of concern or compassion among religious leaders. Understanding this gap is essential. If mosques are among the most trusted institutions within Muslim communities, they may also represent an important opportunity for addressing addiction in culturally and religiously sensitive ways.

For this reason, examining how addiction is perceived within Muslim communities and exploring how mosques can participate in prevention, support, and referral systems is an important area of research.

1.4 Statement of the Problem

Although addiction is widely recognized as a major public health crisis in the United States, its presence within Muslim communities often remains overlooked or under-discussed. Cultural

[11] Padela, Aasim I.,Padela and Rania Awaad. "The Need for Culturally Competent Mental Health Care for Muslim Americans." *Journal of Muslim Mental Health* 12, no. 1 (2018), https://doi.org/10.3998/jmmh.10381607.0012.101

stigma, religious expectations, and concerns about community reputation contribute to a climate of silence around addiction.[12] This silence creates several challenges. First, individuals struggling with addiction may feel isolated and reluctant to seek help. Fear of judgment or social consequences can prevent individuals and families from discussing addiction openly or accessing professional treatment services.[13] Second, mosques and community leaders may lack structured frameworks for responding to addiction within their congregations. While many religious leaders offer pastoral support, few mosques have formal systems for prevention education, early intervention, or referral to professional treatment services.[14] Third, the lack of open conversation about addiction may reinforce misconceptions within communities. When addiction is rarely discussed, it may continue to be perceived primarily as a moral failure rather than a complex, medical, and psychological condition.[15] These challenges highlight the need for greater understanding of addiction within Muslim communities and the potential role of mosques in supporting individuals and families affected by addiction.

1.5 Scope of the Study

Given that addiction is a complex and multifaceted issue, it is important to define the scope of this study clearly. The study also focuses primarily on the communities and institutional response

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[12] Ayşe Ciftci, Nev Jones, and Patrick Corrigan. "Mental Health Stigma in the Muslim Community." *Journal of Muslim Mental Health 7, no. 1 (2013): 17–32,* https://doi.org/10.39981607.0007.102

[13] Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health 2023. Rockville, MD*: U.S. Department of Health and Human Services,* 2023, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

[14] Wahiba Abu-Ras and Lance Laird. "How Muslim Religious Leaders Provide Counseling." *Journal of Religion and Health 50, no. 1 (2011): 202–215,* https://doi.org/10.1007/s10943-010-9393-4.

[15] National Institute on Drug Abuse, Brains, Behavior: The Science of Addiction. Bethesda, MD: *National Institute of Health,* 2020(Bethesda, MD: National Institute of Health, 2020)https://nida.gov/publications/drug-brains-behavior-science-addiction.https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction.

to addiction in the United States, with particular attention to community members connected to mosque environments. While addiction is a global phenomenon affecting Muslims in many countries, this study concentrates on the American context where Muslim communities interact with a broader healthcare system, diverse cultural environments, and varying levels of access to addiction treatment. The aim of this study is not to evaluate specific treatment programs or medical interventions but rather to understand how addiction is perceived within Muslim communities and how mosques might serve as supportive institutions for prevention, education, and referral and support.

Additionally, this study explores the perspectives of several groups within the community, including: Muslim community members, Imams and mosque leaders, healthcare professionals, and individuals involved in recovery work. By bringing together these perspectives, the study seeks to identify gaps in awareness, barriers to help-seeking, and opportunities for collaboration between religious institutions and healthcare systems.

1.6 Personal and Ministerial Location

This Doctor of Ministry project emerges from my lived experience as both a practicing family physician and a member of the Muslim community. For nearly two decades, I have provided care for patients across the lifespan, including many individuals and families facing addiction, mental health concerns, and chronic illness.

In clinical practice, I have repeatedly encountered Muslim patients who delayed seeking help because of stigma, fear of community judgment, or uncertainty about available resources.

These experiences have raised important questions about how addiction is understood within Muslim communities and how individuals navigate the intersection of faith, culture, and healthcare. Although addiction is a national public health concern, Minnesota has also experienced a significant rise in opioid-related harm over the past two decades. Since the early 2000s, opioid overdose deaths in Minnesota have increased dramatically, reflecting a broader national trend. Data from the Minnesota Department of Health show that opioid-related deaths have increased several times since 2000, with fentanyl now involved in the majority of overdose deaths in the state. More than one thousand Minnesotans died from drug overdoses in recent years, demonstrating the continuing severity of the crisis [16](Minnesota Department of Health 2023).

As I have observed the increasing number of Muslim patients dealing with mental health and/or addiction, I have also seen the dedication of imams and mosque leaders who strive to support their congregations despite limited resources and training in mental health or addiction counseling. This gap between medical knowledge and pastoral care can leave individuals struggling with addiction feeling caught between two worlds.

These experiences shaped my interest in exploring ways to strengthen collaboration between healthcare professionals, religious leaders, and community institutions. This project, therefore, emerges not only from academic inquiry but also from pastoral concern and practical experience. It seeks to explore realistic and compassionate approaches that reflect both medical

[16] Minnesota Department of Health. 2023. Drug Overdose Deaths in Minnesota. *St. Paul: Minnesota Department of Health. https://www.health.state.mn.us/communities/opioids/data/index.html*

understanding and Islamic ethical principles. These observations directly informed the research questions guiding this study.

1.7 Purpose of the Study

The purpose of this study is to explore how addiction is perceived and addressed within Muslim communities in the United States and to examine how mosques might function as supportive institutions in prevention, education, and referral. Using a mixed-methods design, the study combines survey data, semi-structured interviews, and a literature review to understand community attitudes toward addiction and identify barriers to help-seeking.

The long-term goal of this research is to support the development of a mosque-based framework that can assist imams, mosque boards, and Muslim healthcare professionals in responding to addiction in culturally and religiously informed ways. Muslim communities are evolving in the integration of the Islamic psychology approach in mental health and the field of addiction. Although important initiatives have begun, many remain underdeveloped. Many Christian churches have developed programs such as Celebrate Recovery, while Jewish organizations have established initiatives such as the Jewish Addiction Awareness Network and Beit T'Shuvah. Comparable mosque-based initiatives remain relatively limited, reflecting a gap in mosque-based interventions. This study contributes to the growing conversation around mental health and addiction within Muslim communities by exploring how religious institutions can engage with public health challenges while remaining grounded in Islamic ethical values. By bringing together insights from public health research, Islamic theology, and community

leadership, this project aims to encourage more open conversations about addiction and reduce the stigma that often surrounds it.

1.8 Research Questions

The following research questions guide this study:

1. How is addiction perceived and discussed within Muslim communities in the United States?

2. What cultural, religious, and institutional factors act as barriers that prevent Muslims from seeking help for addiction?

3. How do imams and mosque leaders currently respond to individuals struggling with addiction?

4. What collaborative strategies can strengthen the partnership between mosques and healthcare professionals?

5. What practical guidelines can support mosque-based prevention and referral programs?

1.9 Overview of Methodology

This study utilizes a mixed-methods approach combining quantitative surveys and qualitative interviews. Anonymous quantitative surveys will assess the level of awareness regarding addiction as both a spiritual and mental health issue, identifying the existing stigma that may act as a barrier and openness to mosque-based programming among Muslim adults. Semi-structured interviews with imams, physicians, and community leaders will delve into their

lived experiences within the community, multifaceted challenges they face, and potential collaboration opportunities. This praxis-oriented design aligns with the Doctor of Ministry emphasis on applied theological reflection and community-engaged leadership. This study is not only an academic exercise but also an attempt to contribute to community improvements, empowering leaders with ethically grounded and realistically supported initiatives.

1.10 Structure of the Thesis

This thesis is organized into eight chapters:

Chapter One provides an introduction to the study's context, problem, and purpose. It addresses the critical problem this study seeks to examine and its relevance. It will clearly define the purpose that drives the research.

Chapter Two reviews relevant literature. This section will engage with existing research and theories, identifying the gap.

Chapter Three presents the methodology, including the research design and data collection strategies.

Chapters Four and Five present the findings. Examining both the quantitative and qualitative results in detail.

Chapter Six discusses the core findings of the study, including analysis and interpretation of the data, providing insight and correlation with the literature review that contribute to our understanding of the research problem.

Chapter Seven: Proposes a mosque-based model based on the insight gained from the data, offering a practical framework to address the identified community needs and challenges.

Chapter Eight concludes the study with recommendations and future directions.

CHAPTER 2:

LITERATURE REVIEW

2.1 Substance Use in the United States: General Trends and Epidemiology Context

Addiction in American Muslim communities must be understood within the broader context of Substance abuse in the United States. It is a major public health issue affecting millions of Americans daily. This is reflected in recent federal survey data, which indicates that in 2024, approximately 48.4 million people, or 16.8 percent of the U.S. population aged 12 and older, met the criteria for a substance use disorder within the past year.[17]

The Opioid and Overdose Crisis

The opioid epidemic in the United States has unfolded in three distinct waves, beginning with prescription opioid misuse and later shifting to heroin use before entering its current phase of widespread synthetic opioid abuse like fentanyl[18]. According to historical data, which recorded the total number of drug overdose fatalities increased every year from the late 1990s until 2022, which recorded an age-adjusted overdose death rate of 32.6 per 100,000.[19]

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[17] Substance Abuse and Mental Health Services Administration (SAMHSA), Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 *National Survey on Drug Use and Health* (Rockville, MD: U.S. Department of Health and Human Services, 2025), 24, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases.

[18] Nora D. Volkow and Carlos Blanco, "The Changing Landscape of Drug Overdose," 1073–1075.

[19] Centers for Disease Control and Prevention (CDC), "Drug Overdose Deaths in the United States, 2023–2024," *NCHS Data Brief,* no. 549 (January 2026): 1–2. https://www.cdc.gov/nchs/data/databriefs/db549.pdf.

This broader national context provides an important foundation for understanding substance use patterns within minority communities, including Muslims. The current period shows progress, which remains delicate and unstable. The CDC data show that between late 2023 and late 2024, approximately 79,000 to 80,000 people died from overdoses, which represents a 24 to 27 percent decrease from the estimated 110,000 deaths in 2023[20]. Even with this sharp drop, the 2024 overdose death rate remains well above levels we saw a decade earlier, and synthetic opioids are still at the forefront for the majority of deaths.[21] These national trends also shape the experience of specific communities. From a Muslim-oriented clinical perspective, this environment is concerning because it normalizes the use of dangerous drugs in everyday life. G. Hussein Rassool argues that contemporary addictive behaviours have become part of the "fabric of society," and people now use powerful opioids, benzodiazepines, and synthetic drugs as essential elements of their daily existence.[22] He notes that prescription psychoactive medications (e.g., sedatives and pain medications) from Western nations are also a major pathway for developing iatrogenic addictions [23]. Additionally, this changing opioid landscape creates special conditions for some faith-based minority groups, including Muslims, within its context. As immigrant and second-generation families navigate American workplaces, health systems, and social networks,

[20] Ibid

[21] Nora D. Volkow and Carlos Blanco, "The Changing Landscape of Drug Overdose, 1999–2021," *Nature Medicine* 29, no. 5 (2023): 1072. https://doi.org/10.1038/s41591-023-02316-4.

[22] G. Hussein Rassool, Treating Addiction from an Islamic Psychology Perspective (Abingdon, Oxon: Routledge, 2025 2-4, 12–13.

[23] Ibid., 2–3.

they do so in a context where opioids may be prescribed liberally for pain, and where diverted or illicit fentanyl has become increasingly common in many communities[24]

Alcohol and Polysubstance Use

Although opioids usually capture media attention, alcohol remains the most commonly used and misused substance throughout the United States. The 2024 National Survey on Drug Use and Health estimated that 29.5 million people aged 12 or older met criteria for alcohol use disorder in the past year, and that nearly half of all adults reported current alcohol use.[25] The frequency of heavy episodic drinking continues to exist as a major problem for college students and young adults. However, some pandemic-related metrics have shown minor improvements since COVID-19 emerged.[26]

Researchers noted a rising trend of polysubstance use, which includes alcohol and drugs like benzodiazepines, stimulants, and opioids. This pattern creates challenges for medical evaluation and therapeutic procedures.[27] The alcohol- centered atmosphere presents a particular challenge for Muslims because their faith prohibits all forms of intoxicants, especially under conditions where they face pressure from their social groups. Rassool observes that Islamic doctrine has identified use as a source of both spiritual and social peril, but contemporary

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[24] Padela et al. The Need for culturally competent Mental health care for Muslim Americans, 2023, 498–99; Rassool, *Treating Addiction from an Islamic psychology perspective,* 202, 2–4.

[25] Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 *National Survey on Drug Use and Health* (Rockville, MD: SAMHSA, 2025).

[26] Ibid., 22-24.

[27] Volkow and Blanco, "The Changing Landscape of Drug Overdose,1999-2021" 1073–75.

drinking patterns continue to affect Muslim people and their families.[28] Studies of Muslim-majority countries and Muslim-minority communities show a rise in alcohol consumption in some contexts and hidden and episodic heavy drinking in others.

As young Muslims move through schools, universities, or workplaces in America, they encounter two conflicting cultural norms - the prohibition of alcohol in the Qur'an, and the strong social norm in which drinking alcohol use is treated as a rite of passage.[29] Alcohol and other substances may become an unhealthy way for many young Muslim adults who feel a lack of connection, or who experience unequal treatment because of their ethnic or religious background, to cope with feelings of stress, loneliness, and/or isolation.[30]

The Treatment Gap

A critical concern in this context is that so many individuals struggle with addiction without adequate support. Most people with an addiction will never find a treatment center that will work for them. According to the 2024 National Survey on Drug Use and Health (NSDUH) statistics, only about one out of four individuals (approximately 25%) of those diagnosed with a substance use disorder received some kind of specialized assistance. That means that for every one individual that contacts a clinic or counseling center, there will be three others who do not receive care.[31] The difference between those who receive assistance and those who do not is

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[28] G. Hussein Rassool, *Treating Addiction from an Islamic Psychology Perspective* (Abingdon, Oxon: Routledge, 2025,2–3,15–16

[29] Zeenah Adam and Colleen Ward, "Stress, Religious Coping and Wellbeing in Acculturating Muslims," *Journal of Muslim Mental Health* 10, no. 2 (2016): 3–26. https://doi.org/10.3998/jmmh.10381607.0010.201

[30] G. Hussein Rassool, *Treating Addiction from an Islamic Psychology Perspectiv*e (Abingdon, Oxon: Routledge, 2025),8-10

[31] Substance Abuse and Mental Health Services Administration (SAMHSA), NSDUH 2024, 52–55.

described as the ‘treatment gap’ by scholars and is attributed to several factors, including insufficient access and insurance, disorganization of systems, stigma, and the belief that the services available to them do not represent who they are or what they believe in.[32]

Multiple obstacles exist for Muslims; the obstacles are even more pronounced, as noted by Rassool, based on both clinical experience and research. The fear of negative judgment and difficulty finding culturally and religiously appropriate environments can result in Muslims not utilizing addiction services, even when services are theoretically accessible.[33] Rassool also discusses how the standard biomedical model, while useful for managing symptoms, may overlook significant spiritual and social elements when it comes to understanding and finding relief from suffering, and overcoming addiction may result in incomplete treatment, as the holistic approach should include pharmacological and therapeutic psychosocial interventions.[34]

The researchers found that patients who enter treatment without integration of their religious beliefs experience lower commitment to continue treatment, which leads to treatment termination because patients believe that recovery requires them to abandon their faith.

Keshavarzi et al. (2021) emphasize that religious beliefs play a central role in psychological healing, and comprehensive treatment cannot be separated from these beliefs.[35]

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[32] Catherine Tomko, Mark Olfson, and Ramin Mojtabai, “Gaps and Barriers in Drug and Alcohol Treatment Following Implementation of the Affordable Care Act,” *Drug and Alcohol Dependence Reports* 5 (2022): 100115. https://doi.org/10.1016/j.dadr.2022.100115b)

[33] G. Hussein Rassool, *Islamic Counselling and Psychotherapy: An Introduction to Theory and Practice,* 2nd ed. (Abingdon, Oxon: Routledge, 2025), 321–322

[34] G. Hussein Rassool, *Treating Addiction from an Islamic Psychology Perspectiv*e (Abingdon: Routledge, 2025), 56–66

[35] Hooman Keshavarzi et al., eds.*, Applying Islamic Principles to Clinical Mental Health Care: Introducing Traditional Islamically Integrated Psychotherapy* (New York: Routledge, 2021), 267-274.

When secular organizations design services without consideration for spiritual beliefs, this creates a barrier that prevents Muslim patients from accessing mainstream treatment facilities that use scientifically proven methods.[36]

National epidemiologic work now confirms that American Muslims do experience substance use disorders—and that their patterns are both similar to and distinct from those of the general population. The 2023 study of Ragheb and her team used data from a U.S. national survey to show that out of 372 Muslim participants, 10.9 percent had experienced alcohol or drug addiction, while 18.4 percent reported lifetime tobacco use, compared with non-Muslim respondents, Muslims had lower rates of alcohol use disorder, higher rates of tobacco use disorder, and similar rates of other substance use disorders, but poorer emotional functioning and a strong role for stigma in shaping help-seeking. Muslims experience addiction problems because religious and cultural stigma create additional treatment challenges, which must be addressed alongside broader treatment gaps affecting the general population.[37]

Why This National Context Matters for American Muslims

These national trends must be understood first to enable researchers to study addiction within American Muslim communities. America faces two challenges on the forefront. America faces to challangeson the forefront. On one hand, Muslims inhabit a nation that still experiences an overdose epidemic while its citizens face substantial alcohol-related dangers and have

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[36] Institute for Social Policy and Understanding 2021 *Institute for Social Policy and Understanding (ISPU), Substance Use, Addiction, and Recovery*: Exploring Patterns and Perspectives Among American Muslims (Dearborn, MI: ISPU, 2026), https://research.ispu.org/substance-abuse.

[37] Heba Ragheb, Shireen Ahmad, Sarah Uddin, Bernard Le Foll, and Ahmed N. Hassan, "The Prevalence and Treatment Utilization of Substance Use Disorders among Muslims in the States: A National Epidemiological Survey," *The American Journal on Addictions* 32, no. 5 (2023): 498–502. https://doi.org/10.1111/ajad.13664Digital Object Identifier (DOI)

relatively easy access to both legal and illegal psychoactive substances. On the other hand, Islamic law and ethics clearly prohibit intoxicants, frame the body as a trust from God, and situate harmful habits within a moral and spiritual narrative.[38]

The two opposing realities create both risks and unique protective factors. Established religious rules together with societal expectations serve to protect people from substance abuse by creating standards that deter them from using drugs; however, established standards can increase shame, leading individuals to conceal their problems and delay seeking help.[39]

For American Muslims, addiction does not arise in a vacuum. This phenomenon stems from three interrelated factors, including a national setting that is similarly affected by problems related to drug/alcohol use, a lack of sufficient treatment options, and a religious framework that inhibits drug/alcohol and a set of interconnected factors. These factors include biopsychological and social dimensions, including the tension between maintaining religious identity and adapting to broader societal expectations, as well as experiences of immigration and acculturation that contribute to internal stress and identity conflict.[40] At the same time, exposure to islamophobia intensifies the psychological strain and affects overall well-being.[41] The subsequent sections of this chapter examine the epidemiology of substance use in Muslim Americans, access to

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[38] G. Hussein Rassool, *Treating Addiction from an Islamic Psychology Perspective (*Abingdon, Oxon: Routledge, 2025), 41-46

[39] Institute for Social Policy and Understanding 2021I*nstitute for Social Policy and Understanding (ISPU)*, Substance Use, Addiction, and Recovery: *Exploring Patterns and Perspectives Among American Muslims* (Dearborn, MI: ISPU, 2026), https://research.ispu.org/substance-abuse.

[40] Anisah Bagasra and Mitchell Mackinem, "An Exploratory Study of American Muslim Conceptions of Mental Illness," *Journal of Muslim Mental Health* 8, no. 1 (2014), https://doi.org/10.3998/jmmh.10381607.0008.104.

[41] Ramy Bassioni and Kimberly Langrehr, "Effects of Religious Discrimination and Fear for Safety on Life Satisfaction for Muslim Americans," *Journal of Muslim Mental Health 1*5, no. 1 (2021). https://doi.org/10.3998/jmmh.133

treatment options, and the role of faith, imams, and mosques, as well as emerging approaches to recovery.

2.2 Muslims in America: Demographic Diversity, Acculturation, and Psychosocial Stressors

The American Muslim community in the United States is one of its most diverse religious groups, including Muslims from African, South Asian, Arab, Black American, and Latino backgrounds, as well as growing numbers of converts.[42] The different subgroups show distinct patterns of acculturation stress, referring to the psychological strain that occurs when Islamic beliefs interact with the norms of dominant cultures.[43] The Twin Cities of Minnesota reflect national diversity, including a substantial East African population, which specifically includes Somali residents along with Arab and South Asian communities. The first- and second-generation residents face dual identity challenges within a broader context of increasing substance use and mental health concerns.[44]

Acculturation and the "Immigrant Paradox"

Research on Muslim mental health studies demonstrates that Muslims living in Western societies experience increasing psychological stress over time, and the behavioral patterns, including substance use, may begin to resemble those of the broader population.[45]

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[42] Saher Selod, Dalia Mogahed, Erum Ikramullah, and Sarah Baker, American Muslim Poll 2025: *Evolving Electorate, Enduring Challenges* (Dearborn, MI: Institute for Social Policy and Understanding, 2025), 13.https://www.ispu.org.

[43] Nigar G. Khawaja, "Acculturation of the Muslims Settled in the West," *Journal of Muslim Mental Health* 10, no. 1 (2016), https://quod.lib.umich.edu/j/jmmh/10381607.0010.102/.

[44] Institute for Social Policy and Understanding (ISPU), *Substance Use, Addiction, and Recovery: Exploring Patterns and Perspectives Among American Muslims* (Dearborn, MI: ISPU, 2023). https://research.ispu.org/substance-abuse.

[45] Saara Amri, "Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust," *Journal of Muslim Mental Health* 7, no. 1 (2013), https://doi.org/10.3998/jmmh.10381607.0007.104.

This "immigrant paradox" suggests that first-generation immigrants use fewer drugs, but their U.S.-born descendants face higher drug use risks due to increased social integration, cultural shifts, and peer pressure.[46] Muslim American youth often experience their identity through a "hyphenated identity" which combines their home religious values with the secular values they observe in American society. This can lead to "spiritual homelessness". This tension can lead to identity fragmentation and increase psychological stress, which may contribute to poor coping mechanisms, such as substance use and digital addiction.[47]

Islamophobia as a Psychosocial Stressor

Islamophobia functions as a persistent psychological and social stressor that affects various Muslim communities in the United States. Studies have shown that individuals who experience religious discrimination together with negative media representations show higher levels of anxiety, depression, and post-traumatic stress disorder symptoms and reduced life satisfaction.[48] National survey data demonstrate that Muslims report elevated levels of psychological stress due to Islamophobia, emotional stress related to experiences with exclusion, and identity-based discrimination.

Racial Inequities and the Minnesota Context

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[46] Institute for Social Policy and Understanding (ISPU), *American Muslim Poll 2023: Perspectives on Identity, Stigma, and Belonging (Dearborn, MI: ISPU, 2023). https://www.ispu.org.*

[47] Omer Suleiman, *Exploring the Faith and Identity Crisis of American Muslim Youth* (Yaqeen Institute, 2017), https://yaqeeninstitute.org. https://yaqeeninstitute.org.

[48] Ramy Bassioni and Kimberly Langrehr, "Effects of Religious Discrimination and Fear for Safety on Life Satisfaction for Muslim Americans," *Journal of Muslim Mental Health 1*5, no. 1 (2021), https://doi.org/10.3998/jmmh.133.

In Minnesota, these national trends are further intensified by existing racial disparities, which contribute to higher rates of fatal overdose. Data from the Minnesota Department of Health (MDH) indicate that Black Minnesotans face a significantly higher risk of opioid related overdose compared to white residents.[49] Somali and other East African Muslims are represented within these statistics. They often experience additional barriers related to stigma, fear of social isolation, and access to care.[50] For these same reasons, addiction has been underreported, reluctance to engage formal medical systems contributes to the opioid crisis. Fentanyl is often described as a "silent killer," affecting young adults navigating social, educational, and economic pressure[51].

The "Model Minority" Pressure and Hidden Addictions

South Asian and Arab Muslim families often emphasize high levels of academic and professional success, which contributes to the development of a "model minority" stereotype. These expectations, along with religious and cultural expectations, can discourage open discussion of mental health struggles.[52]

Young people face pressure to succeed academically while demonstrating their faith through positive actions, making it difficult to express vulnerabilities. Consequently, addictions

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[49] Minnesota Department of Health, Drug Overdose Deaths in Minnesota, 2023 (St. Paul, MN: MDH, 2023), https://www.health.state.mn.us.

[50] Institute for Social Policy and Understanding (ISPU), *Substance Use and Addiction in Muslim Communities* (Dearborn, MI: ISPU, 2023), https://research.ispu.org/substance-abuse.

[51] Minnesota Department of Health, *Drug Overdose Deaths in Minnesota, 2023* (St. Paul, MN: MDH, 2023), https://www.health.state.mn.us.
Institute for Social Policy and Understanding (ISPU), *Substance Use and Addiction in Muslim Communities* (Dearborn, MI: ISPU, 2023), https://research.ispu.org/substance-abuse.

[52] Saher Selod, Dalia Mogahed, Erum Ikramullah, and Sarah Baker, American Muslim Poll 2025: *Evolving Electorate, Enduring Challenges* (Dearborn, MI: Institute for Social Policy and Understanding, 2025), 13. https://www.ispu.org.

often develop in "hidden" forms, such as the misuse of stimulants for performance or compulsive use of digital content for stress relief.

2.3 Understanding Addiction: Clinical Definitions and Pathophysiology

Addiction requires medical understanding before it can be meaningfully assessed within a religious or community-based research context. Modern clinical science has shifted away from viewing addiction as a simple lack of willpower, instead defining it as a chronic, relapsing brain disease characterized by compulsive substance seeking despite harmful consequences.

Clinical Criteria: The DSM-5-TR Framework

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) serves as the primary diagnostic framework used by clinicians in the United States.[53] The term "addiction" is replaced by Substance Use Disorder (SUD) to reflect the varying levels of severity that the condition represents. This assessment requires the use of 11 criteria, organized into four groups:

• Impaired Control: Includes taking larger amounts of a substance than intended and unsuccessful attempts to cut down or regulate use.

• Social Impairment: Involves failure to fulfill major obligations at work, school, or home, and may withdraw from important social or recreational activities.

• Risky Use: Involves using substances in physically hazardous situations or continuing use despite knowing it causes persistent physical or psychological problems.

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[53] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders:* DSM-5-TR, 5th ed. (Washington, DC: American Psychiatric Association Publishing, 2022).

• Pharmacological Indicators: Include the presence of tolerance (needing increased amounts to achieve the same effect) and withdrawal (physical symptoms when the substance is not present).

Pathophysiology: The Hijacked Reward System

The biological basis of addiction can be understood through the Brain Disease Model of Addiction (BDMA), which explains how repeated exposure to addictive substances alters the brain's internal communication system.[54]

The mesolimbic dopamine system plays a central role in this process. In a healthy state, the circuit functions properly to provide rewards for essential life-sustaining activities, including eating and social bonding through dopamine release, a neurotransmitter that induces pleasure and motivation. Addictive substances lead to an extreme and unnatural increase of dopamine in the nucleus accumbens.. The brain responds to these dopamine surges by decreasing dopamine receptor sensitivity, which leads to neuroadaptation, resulting in the person losing their capacity to experience pleasure from natural rewards, and the substance becomes necessary to maintain a baseline state. The process causes damage to the prefrontal cortex, which governs executive function and impulse regulation in the brain. The person with addiction experiences an intense desire to use drugs, which results in the heightened "go" signal and impaired "brake" signal for

[54] Nora D. Volkow, George F. Koob, and A. Thomas McLellan, "Neurobiologic Advances from the Brain Disease Model of Addiction," *New England Journal of Medicine* 374, no. 4 (2016): 363–371, https://doi.org/10.1056/NEJMra1511480.
George F. Koob and Nora D. Volkow, "Neurobiology of Addiction: A Neurocircuitry Analysis," *The Lancet Psychiatr*y 3, no. 8 (2016): 760–773. https://doi.org/10.1016/S2215-0366(16)00104-8.

regulating drug use. This chronic exposure to repetitive addictive substances also alters glutamate signaling pathways, disrupting communication between the prefrontal cortex and reward centers. This impairs decision-making, increases impulsivity, and weakens the brain's ability to regulate craving and behavior.

The figure below demonstrates this cycle through repeated phases of reward, stress, and craving, driven by changes in brain circuits that affect motivation and self-control.[55]

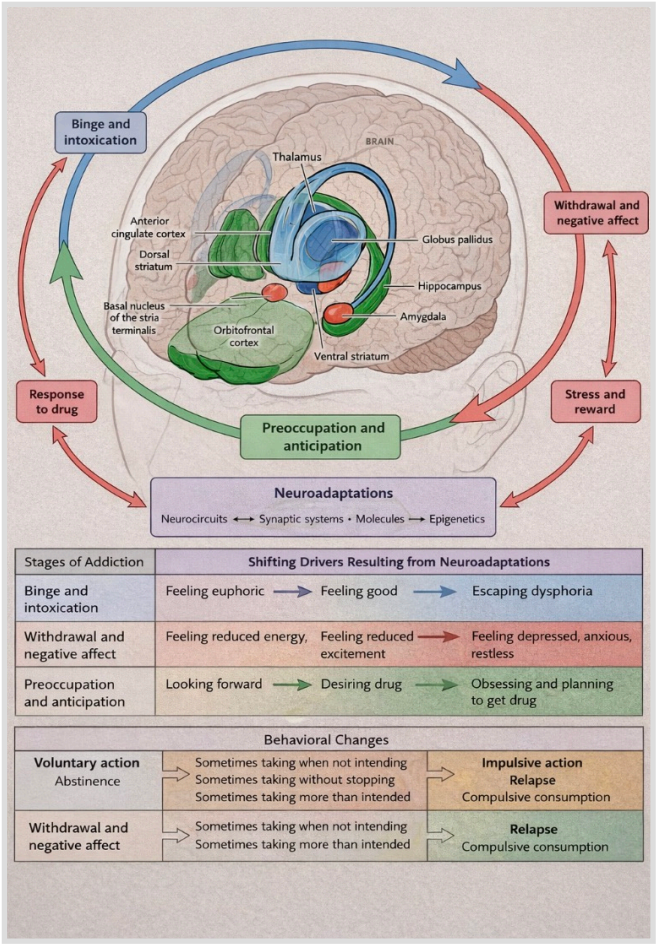

Figure 2.1. Conceptual model of the addiction cycle illustrating binge/intoxication, withdrawal/ negative affect, and preoccupation/anticipation. Adapted from Koob and Volkow (2016).

[55] Koob and Volkow, "Neurobiology of Addiction: A Neurocircuitry Analysis, 760–773.

Islamic Theological Perspectives on Addiction and Illness

Modern clinical models often explain addiction mainly through neurobiological, psychological, sociopsychological, or other theories. While these approaches are important, Islamic thoughts offer a broader and more integrated understanding. It does not separate the physical, psychological, and spiritual, but sees the human being as a whole.

In Islamic tradition, addiction is viewed as a state of imbalance within the human self influenced by internal and external factors. This framework conceptualizes the human self as consisting of interconnected inner faculties. In Islamic psychology, addiction views the self as consisting of the Qalb (heart), Aqal (intellect), Nafs (self), and Ruh (spirit). These elements are deeply connected; when one is disrupted, it affects the entire person. This perspective allows addiction to be seen as a spiritual and ethical struggle that requires a holistic response.

In this framework, addiction can be seen as a state in which the lower self (nafs) begins to take control. As this happens, the role of the intellect (ʿaql) becomes weaker, and the moral awareness of the heart (Qalb) is affected. Classical scholars such as Al-Ghazālī explain that when a person repeatedly engages in harmful actions, it gradually changes the condition of the heart. Over time, what once felt wrong may begin to feel normal. Similarly, Ibn al-Qayyim described how habits can shape a person's behavior and inclinations, leading to reduced self-control and continued harmful patterns[56]. These ideas closely reflect what is now described in modern clinical language as conditioning and dependency. Building on this model, contemporary Islamic psychology further develops this understanding by integrating spiritual and clinical perspectives.

[56] Sarah Mohr and Latifat I. Ahmed, "Islamically Integrated Strategies for Addiction Treatment: Al-Ghazali's Ilm-un-nafs, RCBT, MI, and the Stages of Change," in Clinical Applications of Islamic Psychology, ed. Amber Haque and Abdallah Rothman (Abingdon, Oxon: Routledge, 2023), 269-271.

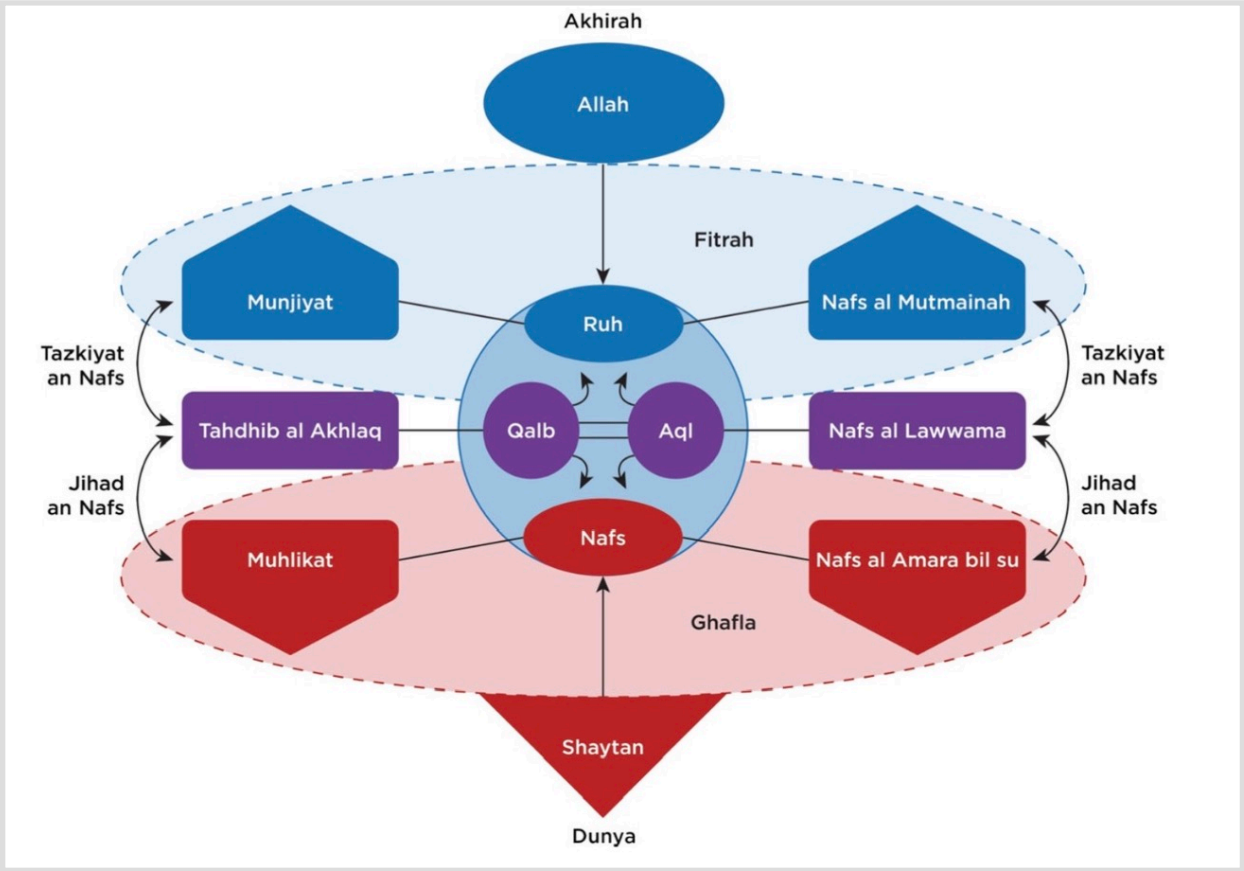

Figure 2.2. Conceptual model of the human self in Islamic psychology (qalb, ʿaql, nafs, rūḥ), reproduced from Rothman and Coyle 2018.[57]

Contemporary Islamic psychologists also understand addiction as a multidimensional condition. It involves spiritual disconnection, impaired thinking, and emotional distress. Muslim scholars such as Amber Haque and Abdallah Rothman propose that well-being in Islam depends on balance within the inner self. When this balance is disturbed, psychological distress can develop. Once this is understood, addiction is not explained only as sin or a biological condition[58] . Instead, it involves multiple dimensions, including spiritual disconnection, impaired

[57] Abdallah Rothman and Adrian Coyle, "Toward a Framework for Islamic Psychology and Psychotherapy: An Islamic Model of the Soul," *Journal of Religion and Health* 57 (2018): 1731–1744, https://doi.org/10.1007/s10943-018-0651-x.

[58] Rothman and Coyle, " Framework for Islamic psychology," 1735

thinking, and repeated behavioral patterns. This multidimensional understanding of the human self is illustrated in Figure 2.2 above.

thinking, and repeated behavioral patterns. Similarly, Malik Badri emphasizes that treatment should address both the inner spiritual state and outward behavior.[59]

The prohibition of intoxicants, therefore, is not only a moral rule, but also a protective measure; it aims to preserve human dignity and well-being. This is connected to the objectives of Islamic law (Maqasid al- Shari'ah), especially the preservation of intellect, life, and family. As noted in contemporary Islamic psychology, Islamic teachings consistently seek to promote benefits and prevent harm. In this sense, addiction can be seen as something that affects not only the individuals but also the wider community. In this sense, addiction can be seen as something that affects not only the individual but also the wider community[60]. This framework allows for a more balanced and compassionate response to addiction.

At the same time, while personal responsibility is important, Islamic thought also recognizes human weakness and the influence of environment and habit. In my clinical experience, many individuals struggling with addiction are not simply making isolated choices, but are influenced by ongoing emotional, social, and behavioral pressures. This understanding helps move the discussion away from blame and toward support and recovery.

Islamic Jurisprudence provides a structured ethical framework for addressing harm, rather than functioning as a purely prohibitive system. Islamic laws incorporate principles that prioritize the preservation of human well-being and allow for flexibility in situations of necessity.

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[59]Mohr and Ahmed, "Islamically Integrated Strategies," 270.

[60] G. Hussein Rassool, *Treating Addiction from an Islamic Psychology Perspective* (2025), 82–83.

One key principle is “blocking the means to harm” (Sadd al-dharā’iʿ), which emphasizes prevention.[61] This aligns with broader Islamic emphasis on upstream prevention, where the focus is placed not only on prohibiting harmful acts but also on addressing the condition that leads to them. This idea aligns closely with modern public health approaches that emphasize prevention rather than only treatment.

Another key principle is Necessity (al-ḍarūrāt tubīḥ al-maḥẓūrāt), which allows certain prohibited actions in situations of serious need. This is connected to the idea of choosing the lesser of two harms. In practice, such interventions may be acceptable if they reduce greater harm, even if they are not ideal in principle.[62]

Another important principle is the idea of “ No harm and No reciprocating harm (lā ḍarar wa lā ḍirār) placing harm reduction at the center of Islamic ethics.[63] Together, these principles demonstrate that Islamic law is not rigid, but responsive and thoughtful. They offer a practical framework for addressing complex issues like addiction with both moral guidance and practical flexibility.

2.4 The Jurisprudential Evolution: From Khamr to Synthetic Opioids and Digital Consumption

[61] Ibid., 82.

[62] Ibid., 86–87.

[63] Ibid., 85.

Islamic teachings on intoxicants have strong ties to the main ethical goals that Islamic law intends to achieve. Islamic jurisprudence (fiqh) treats intoxicants as forbidden because this prohibition protects a key Sharīʿah objective that scholars refer to as maqāṣid al-sharīʿah.[64] The preservation of the intellect (ḥifẓ al-ʿaql) stands as one of these objectives, which Islamic scholars regard as essential for human moral responsibility and social well-being. The essence of human cognitive capacity enables people to identify what constitutes right and wrong while they make decisions about ethics and fulfill their spiritual and social duties. The mind suffers from negative impairment through substances and behaviors that create negative effects that extend beyond the individual to society at large.[65]

The Qur'an uses the term khamr to describe intoxicants. The term khamr originally referred to fermented grape beverages, but Islamic jurists historically interpreted it in a broader sense. The scholars used the principle of analogical reasoning (qiyās) to expand the prohibition to any substance that creates intoxication or prevents proper mental functioning. Classical jurists found that the prohibition existed because it served to protect humans from the damaging effects that all intoxicating substances bring to their mental and behavioral capacities.[66]This interpretation allowed Islamic law to remain flexible and applicable to new circumstances, including substances that did not exist during the early Islamic period.

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[64]G. Hussein Rassool, *Treating Addiction from an Islamic Psychology Perspective* (London: Routledge, 2024), 22.

[65] Rassool, Treating Addiction, 82–87.

[66] Yasmin Safian, "An Analysis on Islamic Rules on Drugs," *International Journal of Education and Research* 1, no. 9 (2013): 1–7.

This broader legal reasoning is also reflected in the Qur'anic approaches, which address intoxicants in stages, gradually discouraging and ultimately prohibiting them. The final prohibition appears in the verse:

"O you who believe, intoxicants, gambling, idols, and divining arrows are but defilement from the work of Satan, so avoid them so that you may succeed."[67]

Classical Muslim scholars interpreted this verse as establishing a clear moral and legal prohibition against intoxicating substances. The Qur'an expresses concern about two different matters, which include ritual impurity and the social and psychological damage that results from intoxication. The verse itself connects intoxicants to gambling and other harmful activities because they both create moral and social damage.

Prophetic traditions further clarify this principle. In a widely cited hadith, the Prophet Muhammad ﷺ said:

> "Every intoxicant is khamr, and every khamr is forbidden."[68]

A related narration emphasizes the broader principle behind the prohibition:

> "Whatever intoxicates in large quantities, a small quantity of it is also forbidden."[69]

The traditions establish a clear rule that Islamic jurists use to determine that all mind-altering substances should be classified as khamr. The classical scholars used this rule to assess all intoxicating substances that became available throughout different periods of history.

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[67] Qur'an 5:90.

[68] Muhammad ibn Ismāʿīl al-Bukhārī, Ṣaḥīḥ al-Bukhārī, *Book of Drinks* (Kitāb al-Ashribah), Hadith no. 5580.

[69] Abū Dāwūd, Sunan Abī Dāwūd, Hadith no. 3681.

This approach helps explain how modern addictive disorders develop. Heroin, methamphetamine, fentanyl, and other synthetic opioids did not exist in the communities of classical Islamic times. Islamic jurists use the qiyās principle to assess these substances because they impair intellectual function while causing harm to both the individual and society.

Mansur Ali notes that Muslim scholars historically addressed similar issues when new intoxicating substances appeared in medieval Islamic societies. Scholars used juristic reasoning to show that the fundamental ethical standard of protecting the intellect remained in effect for all substances regardless of the specific ones involved.[70]

Modern addiction medicine provides further insight into why intoxicants are considered harmful. Neuroscience research indicates that addictive substances change the reward pathways in the brain, which disrupts the ability to make effective decisions. The brain's ability to maintain control over impulses and to make judgments on the long-term consequences of drug use deteriorates as people use drugs repeatedly.

The neurological disruption that occurs in this situation aligns with the Islamic belief about intoxication, which can significantly impair decision-making ability. Under the teachings of the Islamic legal tradition, anyone who uses drugs or other addictive substances while having their mental faculties impaired is considered to have diminished human accountability and well-being according to modern neuroscience findings.[71]

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[70] Mansur Ali, "Perspectives on Drug Addiction in Islamic History and Theology," *Religions* 5, no. 3 (2014): 912–928. https://doi.org/10.3390/rel5030912.

[71] George F. Koob and Nora D. Volkow, "Neurobiology of Addiction: A Neurocircuitry Analysis," *The Lancet Psychiatry* 3, no. 8 (2016): 760–773.

The contemporary understanding of addiction has expanded to recognize that an individual can become addicted to more than just a chemical substance. Compulsive gambling, gaming, pornography, and other behavioural addictions constitute dependency that results in various psychological disorders. While people do engage in these behavioural addictions without chemical substances as part of their lives, they are at risk of suffering damage to their cognitive ability, emotional regulation, and moral decision-making.

From an Islamic ethical standpoint, the principle of protecting the intellect allows Islam to explore the notion of behavioural addiction based on its impact on the intellectual capacity of a human being to function at a high level of cognitive ability. G. Hussein Rassool notes that addiction should be viewed within a holistic framework encompassing biological, psychological, social, and spiritual elements. Under this paradigm, substance-based and behavioural addictions adversely affect the human ability to make rational choices or decisions, or have an understanding of what is spiritual.[72] When individuals become compulsively engaged in activities that weaken their self-control or distort their priorities, their capacity to exercise moral responsibility may be compromised.

This perspective allows Islamic scholarship to address emerging forms of addiction in the modern world. The rise of digital technologies has introduced new behavioral patterns that were unimaginable. Online gambling platforms, pornography websites, and social media applications create compulsive engagement patterns that develop into addiction. These behaviors create

[72] Rasool, *Treating Addiction from an Islamic Psychology* 45

psychological dependency, which disrupts their capacity to execute moral and balanced conduct.[73]

Currently, experts in Islamic psychology are beginning to explore how classical texts on the ethics of behaviour can be applied to behavioural addiction issues in the modern world, particularly in relation to the protection of intellect. The scholars emphasize the ongoing struggle to protect the intellect from being diverted, weakened, or removed from its intended state as defined by Shariah. Behavioural addiction to technology and repeated actions may distract our intellects and weaken them, leading to loss of control and other imperfections.

Studies have found that addiction is associated with a wide aspect of health, both physical and psychological, along with an effect on several social aspects, such as family relations, marital strain, and loss of employment, also influencing a person's spiritual well-being. This integrated biopsychosocial- spiritual model urges that effective treatment must address not only physical but emotional struggle and loss of purpose equally.[74] Islamic psychology offers an integrated framework for understanding this phenomenon. Rather than viewing addiction as only a moral failing or a biological disease, Islamic scholars emphasize the interaction between the body, mind, and soul. Abu-Raiya and Pargament(2011) pointed out that some features of Islamic psychology are multidimensional and suggest a vital place for spiritual well-being in the

[73] Mohammad Hashim, "Prevention of Pornographic Addiction: An Islamic Psychology Perspective" (June 2024), https://doi.org/10.31234/osf.io/xgchu.

[74] Hamad Al Ghaferi, Christine Bond, and Catriona Matheson,"Does the Biopsychosocial-Spiritual Model of Addiction Apply in an Islamic Context? A Qualitative Study of Jordanian Addicts in Treatment," *Drug and Alcohol Dependence* 172 (2017): 14–20, https://doi.org/10.1016/j.drugalcdep.2016.11.019.

promotion of mental health and psychological coping.[75] Within this model, recovery involves not only behavioral change but also a spiritual renewal and reconnection with meaningful values.

This holistic perspective aligns with the broader Islamic tradition of moral cultivation. Spiritual practices such as prayer, remembrance of God (dhikr), and repentance (tawbah) can be understood as mechanisms that strengthen self-discipline and restore balance within the individual. There is no objection to the use of medication or therapy to help achieve this goal, provided that acts of worship are integrated into the healing process as a means of dealing with the spiritual aspects of the issue in question.[76]

Integrating traditional Islamic law with the psychology of addiction provides an important framework for helping Muslim communities address addiction. By using Islamic legal principles as a foundation for modern discussions on addiction prevention and recovery, scholars and practitioners can create culturally sensitive treatment modalities. At the same time, these treatment programs and services will need to reflect advances in the fields of psychology and medicine that relate to our understanding of addiction and mental illness.

The prohibition of intoxicants in Islam is a wider argument in favor of human dignity and well-being. The preservation of the intellect is a fundamental principle of Islamic ethics because of its crucial role in human accountability, moral reasoning, and spiritual development. This

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[75] Hisham Abu-Raiya and Kenneth I. Pargament, "Empirically Based Psychology of Islam: Summary and Critique of the Literature," *Mental Health, Religion and Culture* 14, no. 2 (2011): 93–115.

[76] Saida Machouche and Benaouda Bensaid, "An Islamic Spiritual Alternative to Addiction Treatment and Recovery," *Al-Jami'ah: Journal of Islamic Studies* 59, no. 1 (2021): 127–162,https://doi.org/10.14421/ajis.2021.591.127-162.

principle remains relevant in responding to emerging trends of addiction in contemporary society.

2.5 Religion, Religiosity, and Protective and Risk Factors

As discussed in the previous section, Islamic jurisprudence prohibits intoxicants and behaviors that impair the intellect because they undermine the preservation of the intellect (ḥifẓ al-ʿaql), one of the core objectives of Islamic law. While the Shariah lays down prohibitions for human action, it also offers us means of prevention, protection, and cure. Religious beliefs, practices, and a sense of belonging to a religious community are considered some of the protective factors that may hinder the consumption of drugs and the engagement in behavioural addiction. On the other hand, a religious environment can sometimes provide risk factors by causing stigmatisation and confusion for the individual who needs to seek care in the formal health sector. This duality is fundamental in studying the phenomenon of addiction in religious (or Muslim) communities.

According to a growing body of research, religiosity is negatively correlated with drug and alcohol use and is associated with psychological adaptation in a wide array of populations.[77] In Muslim contexts, religion impacts beliefs and values, as well as patterns of behavior and coping mechanisms. Activities such as obligatory prayer (ṣalāh), recommended remembrance of God (dhikr), fasting in Ramadan, and other forms of charitable works and sacrifice help to

[77] Harold G. Koenig, Religion, Spirituality, and Health: *The Research and Clinical Implication*s (West Conshohocken, PA: Templeton Press, 2012).
Lucchetti, Giancarlo, Alessandra Lucchetti, and Harold G. Koenig. "S*pirituality, Religiousness, and Mental Health*: A Review of the Current Scientific Evidence." *World Journal of Clinical Cases* 9, no. 26 (2021): 7620–763. https://pmc.ncbi.nlm.nih.gov/articles/PMC8462234/

inculcate principles of self-control, accountability, and compassion. These practices are coping mechanisms that help protect against addiction.

Bensaid (2021) argues that Islamic spirituality provides a meaningful framework for addiction prevention and recovery because it integrates spiritual transformation with behavioral change. According to Bensaid, addiction recovery in Islamic thought is closely connected to the spiritual process of repentance (tawbah), self-reflection, and moral renewal. Islamic spirituality goes beyond abstinence. It encourages individuals to rediscover their life purpose, responsibilities, and connection with God.[78] The spiritual orientation will enhance recovery motivation while helping people restore their personal identity and life purpose.

Research in Muslim mental health also highlights the protective role of religious identity and community belonging. Hashem et al. (2024) found that Muslim American emerging adults who reported stronger feelings of belonging within their religious community were less likely to report substance use behaviors.[79] The study indicates that social support networks, which exist in Muslim communities unction as protective environments that promote positive behavior standards and provide emotional assistance to their members. People who have strong ties to a community that shares their values tend to avoid engaging in activities that contradict those values. Various researchers have also indicated that religious affiliation plays a role in how individuals cope with difficult situations and overcome adversity and rebound from difficult

[78] Benaouda Bensaid, Salah ben Tahar Machouche, and Mustafa Tekke, "An Islamic Spiritual Alternative to Addiction Treatment and Recovery," *Al-Jāmi'ah: Journal of Islamic Studies* 59, no. 1 (2021): 127–162, https://doi.org/10.14421/ajis.2021.591.127-162.

[79] Hanan Hashem, Haroon Dossani, Minha Ghani, Ahmad Shafaat Ahsen, and Celine Morshed, "Belonging as a Predictor of Substance Use for Muslim American Emerging Adults," *Journal of Muslim Mental Health* 17, no. 2 (2024), https://doi.org/10.3998/jmmh.1176.

times.[80] When people cope using religious coping, they gain psychological resources that help them manage stress and therefore do not need to resort to harmful behaviours. The association between addiction and religious beliefs is complex and carries multiple implications for how individuals engage in religious practices. While many religious teachings inhibit an individual from using drugs, these same teachings also create stigma for individuals who come to view their addiction solely as a moral or spiritual failing. Mental health stigma continues to present major obstacles for many Muslim communities, according to multiple academic studies.[81] People who experience addiction through the lens of sin rather than as a treatable health condition face profound shame and fear of how others may respond. People who need help will avoid treatment because of this societal stigma. As a result, many individuals continue to hide their addiction

from their families, religious leaders, or healthcare providers until it becomes a more serious problem. The longer an individual delays seeking help, the more severe and destabilizing addiction becomes.

Researchers in the field of Islamic psychology have found that mental illness treatment must include both a spiritual component and compassion in the treatment process. According to Bensaid (2021), Islamic teachings emphasize mercy, forgiveness, and preservation of human dignity. Together, these principles create a moral foundation on which the public can develop compassion for those who have a mental illness and are addicted.[82] When religious groups understand these teachings together with correct information about addiction as a medical and

[80] Rania Awaad and Sara Ali, "Obstacles to Mental Health Care in Muslim Communities," Journal of Muslim Mental Health 9, no. 2 (2015).

[81] Ibid

[82] Bensaid, Machouche, and Tekke, "An Islamic Spiritual Alternative to Addiction Treatment and Recovery,

psychological condition, they develop into vital allies for prevention efforts and recovery programs.

Religious beliefs may provide positive benefits in serving as a source of compassion and support for individuals; however, they also pose a challenge to individuals attempting to find help when they are stigmatized for having a substance use problem and struggle to engage in open dialogue about their challenges. Understanding this duality of both positive and negative factors will help develop addiction intervention strategies for the Muslim community.

2.6 Stigma, Help-Seeking Barriers, and Family/ Community Dynamics

Many Muslims feel restricted from utilizing services available in faith-based communities to help those struggling with addictions, due to barriers rooted in family, community, and cultural beliefs. In order to offer solutions to these problems, it is important to understand these barriers. Stigma regarding substance use and mental health is the biggest barrier to accessing care. Many Muslim families try to keep it secret, as it is often viewed as a moral weakness. Research studies indicate that stigma is the second largest barrier preventing Muslims form from accessing mental health services.[83]

It is important to briefly explain the concept of shame, stigma, and guilt as they will be frequently referenced in the discussion of addiction; it requires careful distinction from related constructs. In psychological literature, shame is understood as a self-focused emotion in which

[83] Ayşe Ciftci, Nev Jones, and Allen Corrigan, "Mental Health Stigma in the Muslim Community." *Journal of Muslim Mental Healt*h 7 (2013); Sara Ali, Aafreen Mahmood, Aminah McBryde-Redzovic, Fairuziana Humam, and Rania Awaad, "Role of Mosque Communities in Supporting Muslims with Mental Illness: Results of CBPR-Oriented Focus Groups in the Bay Area, California," *Journal of Muslim Mental Health* 14, no. 1 (2020), https://doi.org/10.3998/jmmh.10381607.0014.101; Institute for Social Policy and Understanding (ISPU). "Substance Abuse and Addiction in the Muslim Community."A Case Study of Alliance Wellness Center (2026).

an individual views the self as fundamentally flawed or inadequate. In contrast, guilt is directed toward specific actions and reflects a sense of wrongdoing rather than a flawed identity.[84] This remorse related to one's action or behavior can be motivating a desire to make amends or changes. Bruce Link and Jo Phalen describe stigma as a process where labeling, stereotyping, and separation lead to loss of status and discrimination. It occurs in the context of power and results in social disadvantage.[85] It can be persistent and operates through many connected processes, including social attitudes and structural inequalities, leading to discrimination. Even if one barrier is reduced, other smay continue making stigma difficult to eliminate.[86]

In a clinical setting, this distinction is important, as guilt may encourage accountability and behavioral change, while shame often leads to withdrawal, concealment, and avoidance of help-seeking. Stigma is also frequently used in discussions of mental health and addiction. Stigma operates at a social level and refers to the negative labeling, stereotyping, and discrimination directed towards individuals with conditions such as substance use disorders, which further reinforces barriers to treatment. [87]

In the Islamic framework, the concept most commonly associated with shame is " haya" (modesty or moral consciousness), which is understood not as self-condemnation, but as a form of moral awareness rooted in one's relationship with God. This understanding is deeply grounded

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[84] June Price Tangney and Ronda L. Dearing, *Shame and Guilt* (New York: Guilford Press, 2002), 10–25.

[85] Bruce G. Link and Jo C. Phelan, "Conceptualizing Stigma," *Annual Review of Sociology* 27 (2001): 367, https://doi.org/10.1146/annurev.soc.27.1.363.

[86] Ibid

[87] R. A. DiComo and M. Mychailyszyn, "The Relationship Between Stigma and Help-Seeking Behaviors Among Refugee, Asylum Seeker, Immigrant (RASI) Populations Specifically of Muslim Origin," *Journal of Muslim Mental Health* 15, no. 2 (2021), https://doi.org/10.3998/jmmh.130.

in prophetic teachings, as reflected in prophetic tradition, where Prophet Muhammad (peace be upon him)stated:

"Haya is part of faith[88], and it is also reported that 'Every religion has a distinct characteristic, and the characteristic of Islam is haya"

Classical and contemporary scholars describe haya as an internal moral compass that restrains wrongdoing while preserving human dignity, rather than negating one's worth.[89] This distinction differs from clinical understanding of shame, which primarily emphasizes the pathological effects on the self. In contrast, haya functions as a protective ethical capacity that encourages accountability. It is also important to note that Islamic teaching maintains a balance between compassion and accountability, emphasizing that individuals are recipients of divine mercy through repentance(tawbah). This allows for restoration rather than permanent moral failure[90]. When moral awareness becomes distorted into internalized shame- an individual begins to equate their struggle with personal worthlessness- it begins to resemble the pathological form described in clinical psychology, leading to despair and concealment. In many Muslim communities, this dynamic is further reinforced by social stigma and concerns about honor and

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[88] Faith consists of more than sixty branches… and ḥayā is a branch of faith,"
Sahih al-Bukhari, no. 9;
Sahih Muslim, no. 35.

[89] Hamza Yusuf, *Purification of the Heart: Signs, Symptoms and Cures of the Spiritual Diseases of the Heart* (translation and commentary on Imam al-Mawlūd).
A. S. Shalaby et al., "Perceived Stigma Toward Individuals with Mental Illness and Their Families: Perspectives of Patients' Relatives in a Multicentric Egyptian Study," *Middle East Current Psychiatry* 32 (2025), https://doi.org/10.1186/s43045-025-00576-0.

[90] A. S. Shalaby et al., "Perceived Stigma Toward Individuals with Mental Illness and Their Families: Perspectives of Patients' Relatives in a Multicentric Egyptian Study," *Middle East Current Psychiatry* 32 2025), https://doi.org/10.1186/s43045-025-00576-0.

reputation. This behaviour intensifies silence around addiction and delays access to seek help.[91] Research indicates that providing education in religious contexts can lessen stigma. Hassan et al. (2021) assessed the effectiveness of a spiritually adapted psychoeducation program called Inspiring Muslim Minds, which was offered in various mosques across Canada. Participants in the program learned about addiction and intervention, resulting in decreased stigma toward substance use disorder as compared to non-participants. The researchers concluded that educational programs in mosques can help improve mental health literacy within Muslim communities.[92]

Family dynamics also play a role in the help-seeking behaviors within Muslim communities. Many Muslims place a high value on family honor and their community's reputation. Kouser and Raheemullah (2024) discovered that the fear of privacy and stigma were significant barriers for many Muslim families when invited to participate in a support group for families of addicted loved ones.[93] These concerns discourage them from discussing addiction openly or seeking external support.

Another challenge is that many traditional community narratives state that Islam prohibits the use of all intoxicants, which causes many Muslims to assume that nobody from their community suffers from addiction. However, research has shown there is a high probability that

[91] R. A. DiComo and M. Mychailyszyn, "The Relationship Between Stigma and Help-Seeking Behaviors," *Journal of Muslim Mental Health* 15, no. 2 (2021).

[92] Hanan Hashem et al., "Belonging as a Predictor of Substance Use for Muslim American Emerging Adults." *Journal of Muslim Mental Health* 17, no. 2 (2024)

[93] Taimur M. Kouser and Amer Raheemullah, "Perceived Barriers to Addiction Family Support Groups in the American Muslim Community." *Psychiatric Services* 75, no. 12 (2024): 1293–1294.

reported cases of addiction are less frequent due only to issues of stigma and secrecy rather than any true lack of cases. (ISPU 2021).[94]

Religious institutions might be beneficial in overcoming the barriers mentioned above, as mosques can often function as community centres where individuals seek help with personal and family problems. Religious leaders may also serve as entry points for families dealing with addiction or mental health problems.[95] Researchers further propose that integrating religious leadership with professional mental health care can also reflect the holistic perspectives found in Islamic psychology. Addiction cannot be addressed effectively without acknowledging both its spiritual and psychological dimensions. Addiction cannot be understood solely from a biological dysfunction or moral standpoint. Biological, psychological, social, and spiritual aspects are interconnected in shaping addiction.[96] To improve addiction outcomes within Muslim communities, two objectives must be addressed: reducing stigma and improving community support systems. When religious communities combine spiritual compassion with evidence-based mental health education, they can create a safe environment for people to seek assistance and engage in recovery from addiction.[97]

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[94] Institute for Social Policy and Understanding (ISPU). "Substance Abuse and Addiction in the Muslim Community."*A Case Study of Alliance Wellness Center* (2026)

[95] Rania Awaad, Eiman Obaid, Taimur Kouser, M.A., and Sara Ali," Addressing Mental Health Through Community Partnerships in a Muslim Community**,"**P*sychiatric Services* Volume 74, Number 1https://doi.org/10.1176/appi.ps.202100505

[96] Ibid

[97] Ibid

2.7 Role and Impact of Faith-Based Programs

Faith-based recovery programs hold a unique position but are often overlooked in addiction treatment. Even though most current-day addiction treatment relies upon biopsychosocial methods, many individuals who suffer from addiction disorders often want more than just clinical help. They seek moral healing, spiritual purpose, and a supportive community. For millennia, religious groups have been positioned to provide these kinds of relationships and existential supports that complement formal treatment approaches. In the Christian, Jewish, and Muslim communities, there are several structured recovery models developed that reflect deliberate integration of spirituality with behavioral change and peer accountability. While there is considerable promise for the use of these approaches based on the existing literature, the amount and quality of evidence across the various faiths vary tremendously.

Alcoholics Anonymous (AA) is the most well-known mutual-help group in history and has been extensively studied as a recovery organization for addictive behaviors. Founded by Bill Wilson and Dr. Robert Smith in 1935 in Akron, Ohio, AA began as a small local group where peers supported each other to stop drinking. It has since expanded into an international fellowship based on the Twelve-Step Model and the idea of mutual accountability through support. The AA model is not linked to any specific denomination but includes strong spiritual references similar to those used by many Protestant churches of the early 20th century and the Oxford Group movements. AA has grown significantly from its early days and is now one of the largest peer support organizations in the world. Current statistics show approximately 100,000 AA groups worldwide and many millions of members. These figures clearly show that peer

recovery models with spiritually oriented approaches hold a special place in recovery. There are more studies and analyses of AA and Twelve-Step Facilitation (TSF) than of most other faith-based treatment options. Because of this extensive body of knowledge, the major systematic review conducted by Cochrane (Kelly, Humphreys & Ferri, 2020) found that AA/TSF produces outcomes equal to or better than the other, traditional alcohol-related treatments in terms of continuous abstinence rates. It is also important to note that one of the key strengths of AA/TSF lies in its emphasis on peer accountability and sustained community support.[98] Peer-reviewed follow-up research helps clarify how these benefits may appear in "real-world" systems: Mundt and colleagues (2012) reported that greater 12-step meeting attendance was associated with lower subsequent medical utilization costs over long-term follow-up, suggesting a plausible pathway for financial benefit at scale.[99]

A study by Pagano et al. (2004) demonstrated that the act of "helping others" in an environment such as AA is connected to a lower probability of relapse and, therefore, supports the idea that the service, accountability, and acceptance experienced within AA is not simply a "spiritual extras," but rather, a tangible behavior that has a direct impact on recovery.[100] Larger longitudinal work similarly suggests that AA involvement and AA-related helping can predict improved outcomes over time (Pagano et al. 2013).[101] Taken together, the data from AA/TSF

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[98] John F. Kelly, Keith Humphreys, and Marica Ferri, "Alcoholics Anonymous and Other 12-Step Programs for Alcohol Use Disorder," *Cochrane Database of Systematic Reviews* 3 (2020): CD012880.

[99] Marsha P. Mundt et al., "12-Step Participation Reduces Medical Use Costs among Adolescents with Alcohol and Other Drug Problems," *Drug and Alcohol Dependence 1*26, no. 1–2 (2012): 124–130.

[100] Maria E. Pagano et al., "Helping Other Alcoholics in Alcoholics Anonymous and Drinking Outcomes: Findings from Project MATCH," *Journal of Studies on Alcohol* 65, no. 6 (2004): 766–773

[101] Maria E. Pagano et al., "The 10-Year Course of Alcoholics Anonymous Participation and Outcomes: A Longitudinal Study," *Substance Abuse* 34, no. 1 (2013): 51–59.

provide a solid comparative base: they illustrate how such programs can generate measurable clinical outcomes and economic benefits from spirituality-based, community-oriented recovery models.

Celebrate Recovery (CR) exemplifies an adaptation of the 12-step model within a more explicitly Christian framework, demonstrating how congregational ecosystems can provide recovery support in local communities of faith. Founded in 1991 by Pastor John Baker at Saddleback Church under the leadership of Rick Warren, Celebrate Recovery embeds addiction recovery within evangelical church life through structured worship, testimony, gender-specific small groups, and biblically grounded step study.[102] The program has seen tremendous growth. However, it still lacks the same peer-reviewed outcome research like that of Alcoholics Anonymous/12-Step Facilitation (AA/TSF). While CR has extensive reach and adequate face validity as a model for the church, it lacks rigorously controlled, outcome-focused studies when compared to AA/TSF.

Similar to other faith-based organizations, Jewish communities have historically responded to the problem of addiction with integrated services. Beit T'shuvah in Los Angeles is one of the best-known examples of a combined residential treatment center, psychotherapy, and twelve-step group with Jewish spirituality, creating a holistic therapeutic environment. Loewenthal (2014) also emphasizes that while the Jewish community has developed faith-based solutions for addiction, there is limited data available regarding the rate of addiction within the Jewish faith group because of stigma and reliance on communal assumptions regarding low

[102] Celebrate Recovery, "About Celebrate Recovery", accessed March 4, 2026, https://celebraterecovery.com/about

incidence.[103] Existing scholarship suggests that religious and spiritual engagement can support meaning-making, identity repair, and treatment engagement for some individuals in Jewish contexts, but rigorous long-term abstinence data tied specifically to Beit T'Shuvah are less prominent in the peer-reviewed literature as AA/TSF evidence.

Compared to other recovery movements that include support groups, formal faith-based recovery movements within the Muslim community are relatively new and have not been extensively studied, highlighting a critical gap in the literature and the need for further development of culturally grounded, faith-based recovery models within Muslim communities in North America. Millati Islami, the first of three Muslim mutual-help fellowship recovery programs developed in America, follows the Twelve-Step approach but adds an Islamic theological dimension, including tawbah (repentance), Taqwā (God consciousness), and reliance upon Allah. Program descriptions for Millati Islami present it as a means for Muslims to attain sobriety, while also enhancing their religious connection.[104] Contemporary efforts can be found in wider Islamic moral and medical traditions based on the idea that the use of intoxicants is harmful to individuals and society; therefore, there is a need for compassionate, yet structured, intervention to assist those who use intoxicants. Mansur Ali (2014) provides the framework necessary to examine these contemporary trends.[105] Despite its conceptual importance and community presence, peer-reviewed longitudinal outcome studies (e.g., relapse, abstinence

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[103] Kate Miriam Loewenthal, "Addiction: Alcohol and Substance Abuse in Judaism," *Religions* 5, no. 4 (2014): 972–984, BeitT'Shuvah.About."Accessed March 04, 2026.https://beittshuvah.org/.

[104] Millati Islami World Services, "What Is Millati Islami and How Did It Start?" accessed March 4, 2026. https://millatiislami.org.

[105]Mansur Ali, "Perspectives on Drug Addiction in Islamic History and Theology," Religions 5, no. 3 (2014): 912–928.

duration, retention) evaluating Millati Islami specifically remain scarce—an important gap that supports the need for more structured mosque-linked pathways and evaluation.

Beyond individual recovery programs, in the past decade, there has been an expanding network of more formalized Muslim mental health organizations across North America. Examples include the Khalil Center, as well as various academic collaborations focused on research in mental health services to Canadian and American Muslims (and many of which are also part of the "Maristan" initiative). These programs focus on generating awareness for mental illness and stigma, educating clinicians, and increasing community capacity to provide services, which are all primary functions of these programs. However, the number of published peer-reviewed research articles on the Muslim population and outcome measures (i.e., periods of sobriety, relapse prevention, and treatment retention) remains both limited and still evolving. This does not indicate these programs are ineffective; rather, it means their outcomes have not yet been studied and published at the same scale as AA/TSF.

To date, the most methodologically robust evaluation of a Muslim community intervention is the Inspiring Muslim Minds (IMM) psycho-educational program, delivered in a mosque setting. Results from a study of participants in the IMM program showed statistically significant improvements in participants' addiction knowledge and reductions in stigmatizing attitudes toward addictions.[106] As a relatively new area, the Muslim community is developing faith-based programs, which include Millati Islami and mosque-based psychoeducation

[106] A. N. Hassan et al., "Inspiring Muslim Minds: Evaluating a Spiritually Adapted Psycho-educational Program on Addiction to Overcome Stigma in Canadian Muslim Communities," *Community Mental Health Journal* 57 (2021): 1408–141.

This uneven evidence landscape should not be interpreted as evidence of ineffectiveness in Muslim community responses. Rather, it reflects the early developmental stage of formal evaluation in this field and underscores the need for rigorous longitudinal research. Such research should examine how mosque-connected and Islamically integrated pathways may support earlier engagement, reduced stigma, and sustained recovery.

To further refine this literature review, it is essential to highlight the Tayba Foundation's "Overcoming Addiction" curriculum, which represents a sophisticated integration of traditional 12-Step methodology and classical Islamic psychology (Ihsan). Unlike secular Alcoholics Anonymous (AA), which relies on a "Higher Power" concept to establish external reliance, Tayba's model identifies this Power as Allah (SWT) and grounds the recovery process in Tawbah (repentance) and Tazkiyat al-Nafs (purification of the soul). While AA focuses on "powerlessness" over a substance, this model focuses on the restoration of the Fitra (innate human purity), arguing that the addiction is a "veil" (Khamr) that can be lifted through the combination of ilm (sacred knowledge) and amal (consistent righteous action)[107]

Mechanisms of Action: Why Fiath-Based Recovery can work (Spiritually, Biologically, Psychologically)

Across the strongest evidence bases (particularly AA/TSF), several mechanisms consistently emerge. First, spiritually framed recovery groups facilitate changes in social

[107] Tayba Foundation, *Overcoming Addiction: An Islamic Approach to Recovery: 12 Steps for the Muslim* (Union City: Tayba Foundation, 2021), 11-14.

networks by replacing substance-using networks with recovery-supportive peers. This is one of the most consistent predictors of sustained recovery (Kelly et al. 2020).[108]

Second, they increase pro-recovery behavioral routines (regular meetings, accountability, structured self-reflection), which reduce relapse risk over time (Pagano et al. 2004).[109] There are several faith-based models available that promote creating meaning and hope, as well as repairing one's identity. All of these mechanisms demonstrate how a faith-based recovery model can address not only behavior, but also identity, meaning, and long-term resilience.

When the literature is examined across traditions, a tiered pattern of evidence emerges. AA/TSF has the strongest evidence base, including systematic review evidence supporting abstinence outcomes and cost savings (Kelly et al. 2020)[110] as well as long-term healthcare utilization findings (Mundt et al. 2012).[111] Celebrate Recovery stands as a successful Christian adaptation, as it effectively implements its core features, yet shows fewer rigorous studies that measure its results. Jewish programs that combine different elements demonstrate active community participation, although available research indicates lower outcomes over extended periods.

Emerging research suggests that spiritually integrated programs such as Tayba's provide substantial "recovery capital" and alleviate the strain on publicly funded health care systems. Although longitudinal peer-reviewed data specifically related to the Tayba curriculum is still

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[108] Kelly, Humphreys, and Ferri, "Alcoholics Anonymous and Other 12-Step Programs."

[109] Pagano et al., "Helping Other Alcoholics," 766–773.

[110] Kelly, Humphreys, and Ferri, "Alcoholics Anonymous."

[111] Mundt et al., "12-Step Participation Reduces Medical Use Costs," 124–130.

developing, its 12-Step-style foundation places it in line with findings from the Cochrane review (Kelly et al., 2020)[112]. This indicates that similarly constructed spiritually integrated programs may equal or exceed clinical-only programs when it comes to long-term recovery rates. Economically, faith-based interventions in the U.S. are estimated to contribute $316.6 billion in annual savings by reducing hospital readmissions and criminal justice involvement.[113] For the Muslim community, the Tayba model specifically addresses the "stigma-relapse cycle" by framing recovery not as a social shaming but as a prophetic journey of returning to Allah. This approach has been recognized by partner organizations, such as Khalil Center, as being essential to improving retention rates of those in treatment who are also members of religious communities.[114]

Taken together, these models highlight the importance of structured peer support, accountability, and spiritual meaning in recovery. However, their direct application within Muslim communities requires cultural and theological adaptation.

2.8 Critical Analysis of Existing Faith-Based Recovery Models and Implications in the Proposed Mosque-Based Model

While examining the faith-based addiction recovery programs, either Christian-centered, such as Celebrate Recovery, and Muslim-adapted frameworks like Millati Islamia, we can find that a similarity emerges in that their values lie not only in their structure but also in their

[112] Kelly, Humphreys, and Ferri, "Alcoholics Anonymous."

[113] Brian J. Grim and Melissa E. Grim, "Belief, Behavior, and Belonging: How Faith is Indispensable in Preventing and Recovering from Substance Abuse," *Journal of Religion and Health* 58, no. 5 (2019): 1713–1750.

[114] Hooman Keshavarzi and Ali Haque, "Outlining a Psychotherapy Model for Muslim Patients," *Journal of Religion and Health 5*2, no. 1 (2013): 230–247.

underlying principles. These models emphasize spiritual transformation, accountability, and community support as a central element of recovery. Studies have shown that faith- based interventions provide meaning-making frameworks that support long-term behavioral change, which improve engagement in treatment.[115]

Although the extensive longitudinal data are not available for Muslim-specific programs, emerging evidence supports a similar pattern. For example, the Inspiring Muslim Mind program demonstrated significant improvements in addiction awareness and reductions in stigmatizing attitudes in the community, suggesting that faith-integrated approaches can positively influence help-seeking behaviors among Muslims.[116] Considerable limitations remain when applying these models to Muslim communities in the United States. Many mosque settings lack formal training, structured referral pathways, and collaboration with health care professionals.

While mosques may provide spiritual support, they do not consistently offer structured services such as safe spaces for meetings and peer-led recovery groups. These insights directly inform the development of the proposed mosque-based intervention model. This model builds on the strength of faith-based approaches- such as spirituality, compassion, and accountability- while also addressing existing gaps. The model aims to normalize help-seeking by framing such a process within a religiously acceptable context, thereby increasing engagement in care. In doing so, the proposed model not only adapts existing faith-based approaches but also addresses the unique cultural and theological barriers that shape help-seeking behaviors in Muslim communities.

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[115] Kelly, Humphreys, and Ferri, "Alcoholics Anonymous and Other 12-Step Programs.

[116] Hassan et al., "Inspiring Muslim Minds,"1408–1417.

CHAPTER 3:

METHODOLOGY

3.1 Introduction

In this chapter, I discuss the methodology methods used for the research surrounding addiction awareness and stigma, together with community-level responses toward addiction in the US Muslim community. The purpose of this study is to investigate how addiction is conceptualized, perceived, and responded to within the Muslim community, to evaluate the role mosques may play in helping to prevent, support, and refer individuals or families affected by addiction appropriately. Additionally, the study aimed to assist in the development of a practical 'Mosque-Based' manual to integrate Islamic ethics, pastoral care, and appropriate medical knowledge in addressing addiction.

This study uses a mixed methods approach, which includes quantitative surveys and qualitative interviews. The mixed method approach allows a more complete understanding of complex issues by combining numerical data with lived experience.[117]

The quantitative survey data provide an overview of community attitudes and perspectives on addiction, while the qualitative interview data will provide more in-depth insight into the leadership perspective and the lived experience of the respondents. Both forms of data (quantitative and qualitative) produce a more complete picture of addiction in the Muslim community and help guide the development of context-sensitive, practical, evidence-based recommendations for treating addiction in this population.

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[117] John W. Creswell and Vicki L. Plano Clark, "Choosing a Mixed Methods Design," *In Designing and Conducting Mixed Methods Research*, 2nd ed. (Thousand Oaks, CA: Sage, 2011), 61–65, https://us.sagepub.com/sites/default/files/upm-binaries/35066_Chapter3.pdf.

3.2 Research Design

A convergent mixed-methods design was used for this research, which provides equal weight to both qualitative and quantitative methods. The study utilized survey and interview data collected within a similar timeframe and analyzed separately, with the two data types later integrated. Within this study, the quantitative component measures levels of awareness, perceived stigma, and attitudes toward addiction among adult Muslims associated with their local mosque communities, while the qualitative component gathered perspectives of imams, health care professionals, and community leaders on how. Addiction is understood and addressed, as well as how mosques can support prevention and help-seeking. According to established mixed-methods guidance, this design is convergent due to concurrent timing (QUAN+QUAL), separate analyses of datasets, and integration occurring during interpretation.[118] When comparing quantitative results with qualitative themes to provide a more comprehensive understanding of the research problem.

Convergent mixed-methods designs are widely accepted as an appropriate way of studying complicated social and health issues because they allow researchers to analyze the statistical patterns across participants' personal accounts.

3.3 Study Setting and Population

This research project focuses on the experiences of individuals affiliated with mosques and Islamic community centers in Minnesota's Upper Midwest region and how these experiences shape religious understanding and approaches to addiction.

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[118] Ibid, 69-73

The survey is open to Muslim adults aged 18 years and older who have attended a mosque. Participants may be regular attendees, occasional participants, or connect with mosques through programming and social networks. The survey will solicit perceptions of addiction, experiences with stigma, barriers to help-seeking, and how mosques may help to prevent and support.

The qualitative interview project aims to obtain insight from a selected group of participants who are in leadership and professional roles within the Muslim community concerning their efforts to treat people who experience addiction. These individuals are imams, professionals versed in mental health, medical doctors who specialize in addiction treatment, and community leaders and members who offer support to individuals in recovery. Participants provide valuable insights regarding how addictions are treated in the Muslim community, how stigma surrounding addiction exists within the community, and how mosques may work collaboratively with health care facilities.

3.4 Quantitative Component: Community Survey

Survey Purpose and Development

The quantitative part of this study was conducted with a survey titled "Addiction in the Muslim Community in the United States: A Faith-Integrated Approach to Prevention, Support, and Referral." The purpose of this survey was to measure community awareness of addiction, attitudes toward individuals with addiction, and perceptions of the role mosques may play in the prevention, support of, and referral to assistance for people with addiction. The survey also collected information about perceived barriers people face when

seeking help for addiction. It also examined whether community members would support educational programs at the mosque related to addiction or mental health. The survey questionnaire was developed based on themes identified in the empirical and conceptual literature on addiction, mental health stigma, and help-seeking behavior, with particular focus on research involving religious or minority communities. Questions were informed by prior studies of stigma toward substance use disorders, attitudes toward treatment, and the impact of religious beliefs on perceptions of addiction.[119] The broader mixed-methods literature also provided a framework for the survey so that key constructs could be compared directly with interview themes in later analysis.

The questionnaire items were organized into sections and addressed the following:

1- Awareness and understanding of addiction.

2- Perceived prevalence of addiction in Muslim communities.

3- Personal or indirect exposure to substance use.

4- Attitudes toward help-seeking; perceived barriers to professional treatment.

5- Support for mosque-based education and programs; perceived connections between mental health and addiction.

6- Protective factors such as faith, family, and community support. Many items are used. Multiple-choice or Likert-type response scales so that analysis could be descriptive and comparative.

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[119] Ayşe Çiftçi, Nev Jones, and Patrick Corrigan, "Mental Health Stigma in the Muslim Community," *Journal of Muslim Mental Health* 7, no. 1 (2013): 20–25,, https://doi.org/10.3998/jmmh.10381607.0007.102., M. A. Ahmed and D. J. Doukas, "Islamic Bioethics and the Role of Imams in Addiction and Mental Health," *American Journal of Bioethics* 16, no. 2 (2016): 47–48,, https://doi.org/10.1080/15265161.2016.1145282.

Draft survey questions were reviewed for clarity, cultural relevance, and theological sensitivity. The wording was kept simple so that people from different educational backgrounds could understand it. Items were adjusted to avoid blame and to reflect a compassionate, Islamically grounded approach to addiction.

Survey Distribution and Data Collection

The survey was distributed through a Qualtrics online survey to approximately 100 Muslim adults aged 18 years and older. Recruitment was conducted using a convenience method, using platforms including WhatsApp groups linked to mosque communities and requests to forward it to additional mosque groups.

Participation in the survey was voluntary and anonymous. Basic demographics such as age, gender, and community role (Imam, mosque leader, health care professional, or general attendee) were collected. A message was attached to the survey that was sent to inform participants of the purpose of the study, the voluntary nature, and measures taken to protect confidentiality before beginning the survey

Sampling Strategy

The study uses a nonprobability convenience sampling strategy. Purposive sampling is frequently used to collect information in community-based health and prevention research when the goal is to describe local patterns and inform practice rather than to produce nationally representative estimates.[120] The study aimed to capture a variety of perspectives within the local Muslim community, including regular attendees, imams, general attendees, and healthcare

[120] Palinkas, Lawrence A., Sarah M. Horwitz, Carla A. Green, Jennifer P. Wisdom, Naihua Duan, and Kimberly Hoagwood. "Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research." *Administration and Policy in Mental Health and Mental Health Services Research* 42, no. 5 (2015): 533–544. https://doi.org/10.1007/s10488-013-0528-y.

professionals. In the context of a convergent mixed-methods design, such sampling is appropriate because the quantitative strand is interpreted alongside qualitative insights rather than in isolation.

Survey Data Analysis

Survey responses were analyzed using descriptive statistics, including frequencies and percentages to summarize patterns in attitudes, perceptions, and experiences related to addiction and stigma. Where appropriate, cross-tabulations were used to explore differences across demographic subgroups such as age, gender, and community role (e.g., imam, healthcare professional, general community member).

The quantitative analysis of the survey will be discussed in Chapter 5. The aim is to provide a clear descriptive picture of the perception of Addiction and attitude in Muslims in a community. These descriptive results will be reviewed and integrated with qualitative findings from the interview.

3.5 Qualitative Component: Semi-Structured Interview

Purpose of Interviews: The semistructured interviews provided space for deeper exploration of experiences, theological reflection, and practical insights. Interviews were focused on personal and professional understanding of addiction, religious institutions, and healthcare responses to obstacles. Interviews also explored possibilities for collaboration between mosques and healthcare systems, including how imams, clinicians, and community leaders imagine shared work in prevention, support, and referral. This qualitative component is

designed to capture the depth and nuance of issues that cannot be fully captured by fixed-response survey items.

Development of Interview Guide: The semi-structured interview guide was developed based on key themes identified from the literature review. Questions were designed to be open-ended, allowing participants to share their perspectives in their own words about sensitive topics related to addiction within the Muslim community. These include areas such as experience with barriers and facilitators of treatment, the role of religious leadership and family, the impact of stigma, and opportunities for mosque-based prevention and support.[121] Efforts were made to ensure questions were respectful and non-judgmental.

The semi-structured format allows the researcher to ensure that core topics are consistently addressed while still providing flexibility for participants to introduce issues they consider important. This approach aligns with the best practices in qualitative and mixed-methods interviewing, especially when working with marginalized or stigmatized topics. Some sample interview questions included were: Do you think addiction exists within Muslim communities? How do communities approach helping individuals with addiction? What role should mosques play in supporting individuals struggling with addiction? What barriers prevent Muslims from seeking professional treatment? Follow-up questions were used when needed to clarify responses and to explore themes that emerged during the conversation.

[121]Ayşe Çiftçi, Nev Jones, and Patrick Corrigan, "Mental Health Stigma in the Muslim Community," *Journal of Muslim Mental Health* 7, no. 1 (2013): 20–25,, https://doi.org/10.3998/jmmh.10381607.0007.102., M. A. Ahmed and D. J. Doukas, "Islamic Bioethics and the Role of Imams in Addiction and Mental Health," *American Journal of Bioethics 1*6, no. 2 (2016): 47–48,, https://doi.org/10.1080/15265161.2016.1145282.

Interview Participant Selection (Purposeful Sampling)

The participants were selected by purposive sampling. Purposeful sampling is used in qualitative and mixed-method research studies to recruit individuals with relevant experience or knowledge on the topic of research.[122] In this study, individuals were chosen because of their professional roles or leadership positions related to mental health, addiction treatment, pastoral care, or community guidance within Muslim communities. Participants include imams, healthcare professionals, addiction medicine specialists, recovery counselors, and community leaders, to gain insight from a variety of people from their regular encounters with addiction-related challenges.

Eligibility for participation in the interview requires that they meet at least one of the following criteria: (1) experience working in addiction treatment or mental health services, (2) a leadership role in the Muslim community, or (3) professional or volunteer experience in supporting individuals or families dealing with addiction. Individuals were contacted directly and invited to participate in a semi-structured interview. Participation was voluntary.

Interview Procedure

For the qualitative part, the goal is to conduct 10-15 interviews with participants in different roles. Interviews were conducted through Zoom or by phone. Each interview lasted approximately 20–30 minutes. With participants' permission, interviews were audio-recorded to ensure an accurate record of their words. Recordings were transcribed, and all identifying information was removed or replaced with pseudonyms. Participants were allowed to decline to answer particular questions or withdraw from the interview at any time without penalty.

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[122] Palinkas, et al., Purposeful Sampling for Qualitative Data Collection and Analysis 533–544.

3.6 Data Analysis and Integration

Qualitative Data Analysis

Qualitative interviews were analyzed by thematic analysis. Transcripts were read multiple times to gain familiarity and then coded according to interview questions. During this process, attention was given to the distinctive individual perspectives of each participant as well as the shared themes.

Integration of Quantitative and Qualitative Data: Findings from both components were integrated using a convergent mixed-methods approach. Survey results and interview themes were combined to answer the research question. This comparison examines how the different data sources reflect shared constructs such as prevalence, stigma, willingness to seek help, and the roles of mosques.

3.7 Researcher Positionality and Auto-Ethnographic Reflection

Doctor of Ministry research often invites the researcher to reflect on their own professional and community experience as part of the interpretive process. In this study, the researcher is a family physician who has cared for patients with addiction and mental health concerns, including Muslim patients, in clinical practice. The researcher is also a member of the Muslim community and has firsthand experience of the cultural dynamics of stigma, silence, and help-seeking surrounding addiction.

These experiences shape the questions the researcher asks and the way findings are interpreted. Auto-ethnographic reflection was incorporated alongside more traditional thematic analysis. The researcher's own reactions, assumptions, and learning during the research process

were documented and used to help interpret how clinical and pastoral perspectives intersect in the data. This self-awareness was intended not to center the researcher, but to acknowledge how positionality influences the interpretation of both quantitative and qualitative findings.

3.8 Ethical Considerations

This study followed the ethical guidelines of The Chicago Theology Seminary Institutional Review Board. No personal identifying information will be collected; participants will be anonymous, and pseudonyms will be used if required. Any potential identifying details will be removed from transcription and reports. Audio recordings, transcripts, and survey data will be stored securely by the researcher, where applicable, and supervisory faculty. Data will be reported in aggregated form to protect specific individuals and congregations.

All participants received clear information about the purpose of the study, the procedures involved, the potential risks and benefits, and the steps taken to protect confidentiality. Care was taken to handle any disclosures about personal or family addiction experiences with sensitivity, and to provide information about appropriate referral resources if needed.

3.9 Limitations of Method

At this point, this study acknowledges several methodological limitations. First, the use of convenience sampling for the survey limits the extent to which findings can be applied to all Muslim populations in the United States. Thus, these results primarily reflect the views of mosque-connected adults in a particular geographic region.

Second, addiction remains a sensitive topic, and some potential participants may choose not to participate or feel uncomfortable sharing their experiences openly. This may lead to underreporting of personal or family struggles with addiction, both in the survey and in interviews, which may not fully reflect the viewpoints of the population studied.

Third, the qualitative sample relies on the purposeful selection of leaders and professionals who were accessible to the researcher. While this strategy is appropriate for gathering information-rich perspectives, it may not capture the full diversity of perspectives within the broader Muslim population.

Despite these limitations, the mixed-methods design strengthens the study by combining breadth and depth. Quantitative data provided a broad descriptive picture, while qualitative narratives added context, nuance, and theological reflection. Together, these strands offer valuable insights into community awareness, leadership perspectives, and opportunities for faith-based, mosque-centered interventions addressing addiction

3.10 Summary

This chapter outlined the research design and methods used to examine addiction awareness, stigma, and community responses within Muslim communities. The study employed a convergent mixed-methods design by combining an anonymous community survey with semi-structured interviews of imams, clinicians, and community leaders. Quantitative and qualitative data were analyzed separately and then integrated through joint displays and narrative synthesis. By pairing community attitudes with leadership perspectives, the study sought to inform the development of a practical mosque-based manual that supported prevention, reduces

stigma, and strengthens referral pathways for addiction recovery. The methodological choices in this chapter are intended to reflect both the theological and the clinical dimensions of addiction care and to contribute to compassionate, culturally responsive approaches within Muslim communities.

CHAPTER 4:

QUALITATIVE DATA REVIEW

4.1 Introduction

After thoroughly reviewing the interview transcripts, several recurring themes were observed across participants. Although the interviewees represented different roles—including psychiatrists, addiction physicians, mosque leaders, community leaders, and recovery advocates-their responses showed strong similarities. Across nearly all interviews, participants strongly acknowledged that addiction exists within Muslim communities, which is often hidden due to stigma and shame. Participants brought attention to delayed help-seeking, family dynamics, mental health issues, and the limited preparedness or resources of mosques to address addiction, as well as resistance within the community to address this adequately. In addition, the interviews emphasize the need for prevention, education, and stronger and consistent collaboration between religious institutions and healthcare professionals.

One of the most consistent themes across the interviews was the acknowledgment that addiction in different forms exists within Muslim communities. Participants from both clinical and religious backgrounds emphasized that substance use among Muslims is not fundamentally different from that of the general population. One psychiatrist explained that substance use patterns among Muslim patients are “about the same” as in other communities, although compared to the general population may make greater effort into hiding their behavior because it is culturally and religiously discouraged (Psychiatrist 1). Another psychiatrist expressed that

addiction among Muslims is “aligned with other groups” and that religion can be protective for some individuals but does not completely prevent substance use (Psychiatrist 2).

Religious leaders also acknowledged the presence of addiction within their communities. One imam described addiction as “a constant reality” that he had observed throughout his years in community work, particularly among youth and families seeking guidance (Imam 1). Another imam similarly stated that substance use is increasing and becoming “alarming,” especially among younger generations (Imam 2). However, both leaders emphasized that the problem was often concealed. As one imam explained, the community frequently hides addiction and avoids discussing it publicly due to fear of social judgment (Imam 1).

Healthcare professionals also echoed the same. One child and adolescent psychiatrist expressed concern that, due to family expectations and higher moral standards, substance use among Muslim youth often remains hidden (Psychiatrist 4). As a result, young people feel pressured to conceal substance use or minimize it when speaking with clinicians. Taken together, multiple interviews suggest that despite the presence of addiction within Muslim communities, the visibility is reduced because of social and cultural pressures.

4.2 Stigma, Shame, and Fear of Judgment Delays Help-Seeking

The second major theme surfaced from the interviews was the strong influence of stigma and shame on help-seeking. One addiction medicine physician simply stated that the barrier to seeking early help is “stigma,” emphasizing how deeply this issue affects care (Addiction Physician). One psychiatrist explained that cultural and religious guilt can cause individuals to

hide substance use because they fear being judged by family members or the community (Psychiatrist 1). Another psychiatrist noted that families often worry about social stigma more than the individual struggling with addiction. (Psychiatrist 2).

One imam explained that families often avoid discussing addiction openly because they fear damage to family reputation and community standing (Imam 2). Concerns about future marriage prospects for children and the possibility of gossip within close-knit communities(Imam 2). A community leader likewise explained that addiction problems may remain hidden for long periods because families prefer to manage them privately rather than seeking professional help, either from a professional or a religious Imam (Community Leader).

The recovery counselor also described stigma as a major challenge within Muslim communities. She noted that it has hindered early treatment, family, or communal support. She explained that families sometimes remain in complete denial about addiction and may avoid openly accepting the problem even after serious consequences occur (Recovery Counselor).

Community leaders similarly described how people may be seen as "corrupted" or as having gone down the "wrong path," which leads families to hide problems rather than seek help. The Muslim recovery counselor also described how denial and silence remain deeply rooted in the community. She shared that even overdose deaths may be described as heart attacks rather than openly identified as substance-related.

4.3 Attempts to Address Addiction Privately Before Seeking Professional Treatment

Families frequently attempt to manage addiction privately before turning to professional treatment services. In some cases, families may initially seek religious guidance or an informal support system of close friends and family. One psychiatrist noted that some parents believe that encouraging their child to pray more or become more religious may help resolve addiction (Psychiatrist 2). Sometimes families hope the problem will resolve on its own without formal treatment (Psychiatrist 4).

Spiritual support can be beneficial, but participants emphasized that addiction typically requires professional intervention. Religious leaders also recounted situations in which families sought guidance from imams before contacting medical professionals. One imam explained that families may approach religious leaders when addiction has already progressed or when previous attempts at treatment have failed (Imam 1). Another imam reported that many families try to handle addiction privately and only reach out to religious leaders when they feel overwhelmed or uncertain about what to do (Imam 2).

Some participants noted that addiction is not always brought to religious leaders. Families may avoid discussing addiction with anyone outside the immediate household due to fear of exposure (Community Leader), or the Imam themselves may not want to address the situation (Community Leader 2, Recovery counselor). The addiction problem often progresses for extended periods before professional treatment is sought.

4.4 Root Causes of Addiction Are Multifactorial and Complex

Addiction does not happen in isolation but is complex and multifactorial. The clinicians emphasized early on that substance use is connected to broader psychological, social stressors, and untreated mental health conditions as important contributing factors.

Conditions such as ADHD, depression, and anxiety may lead individuals to experiment with substances as a form of self-medication, especially among youth (Psychiatrist 1). Trauma, family stress, and mental health disorders such as PTSD and bipolar disorder are significant contributors to substance use (Psychiatrist 3). Bullying, school stress, peer pressure, and online influences are common factors affecting younger patients (Psychiatrist 4).

Participants also discussed the challenges faced by immigrant and refugee communities. One psychiatrist noted that individuals who have experienced war trauma or displacement may struggle with unresolved psychological stress that increases vulnerability to substance use (Psychiatrist 1). Intergenerational conflict and identity struggles were also mentioned as factors affecting youth who feel caught between cultural expectations at home and the broader American social environment by several interviews (Psychiatrist 1; Child and Adolescent Psychiatrist)

The recovery counselor's lived experience provided powerful examples of these dynamics. She described growing up experiencing identity and religious conflict, social pressure, and emotional struggles, later diagnosed with mental health issues, including PTSD, as the child of a refugee family, which contributed to her substance use during early adulthood (Recovery

Counselor). These accounts highlight the complex interplay between mental health, trauma, social stress, and addiction.

Another reason for the increasing rate of addiction is availability. One psychiatrist commented that marijuana may act as a gateway drug; some communities use Khat (Psychiatrist 1). Increased screen adduction in children and young adults is another emerging form of addiction. (Child and Adolescent psychiatrist)

4.5 Mosques Have an Important Role, but Often Lack Training and Resources

Mosques play a potential role in addressing addiction, but also face several limitations. Mosques are important community centers that could support prevention and recovery efforts. The participant generally agreed that mosques are important institutions that could play a stronger role in supporting prevention and recovery, but have limitations in this role due to several factors.

Some participants emphasized that many mosques are not currently equipped to handle addiction or mental health issues effectively for a variety of reasons. One imam stated that many religious leaders lack formal training in counseling and may not have clear referral pathways to professionals (Imam 1). Another imam similarly emphasized the need for awareness programs and training so that mosque leaders can respond appropriately when community members seek help (Imam 2). Another imam mentioned their mosque has a counseling referral pathway, but he himself is not formally trained. He offers spiritual help when asked, but understands the need to

refer to professional therapy for formal and comprehensive mental health or addiction treatment when needed(Imam 3)

Healthcare professionals also understand the importance of collaboration between religious institutions and medical providers. One psychiatrist suggested that imams should maintain lists of local mental health and addiction treatment resources so they can guide families toward appropriate care (Psychiatrist 1). Another psychiatrist recommended that mosques can play a vital role in prevention and focused youth education by inviting professionals to speak about substance use and mental health more regularly (Psychiatrist 2).

Faith-based recovery programs are more common in other religious communities. One psychiatrist noted that in comparison to churches, mosques lack support programs such as recovery groups and community outreach initiatives, which support individuals seeking sobriety (Psychiatrist 1). Muslim communities could develop similar programs tailored to their cultural and religious context.

4.6 Prevention and Education are Essential

Prevention and education are essential in addressing addiction. Addressing addiction requires proactive community education, particularly for young people.

Education about drugs should begin early in childhood so that young people understand the potential consequences of substance use (Psychiatrist 2). Mosques could play an important role by offering educational programs for adolescents and their parents (Psychiatrist 4). The treatment center director explained that many individuals begin using drugs out of curiosity or

peer pressure during adolescence, which makes early education particularly important (Treatment Provider). He emphasized that youth education and stigma reduction campaigns could help prevent substance use before it begins. The recovery counselor also stressed the importance of open conversations within families and communities. Through her experiences, this motivated her to become a licensed addiction counselor and raise awareness. She argued that silence and denial often allow addiction problems to worsen and result in grave consequences, while education and honest dialogue can encourage earlier intervention (Recovery Counselor).

4.7 Culturally Responsive and Faith Awareness care is Limited, but Deeply Needed

The need for faith-based addiction treatment approaches was strongly emphasized. Existing treatment systems are often not designed with Muslim patients in mind. Many programs do not consider Islamic values or family expectations, which may make parents hesitant to support treatment. (Child and Adolescent Psychiatrist).

Muslim-specific addiction programs have only begun to emerge in recent years, while many existing recovery models were developed within Christian faith-based traditions, such as the twelve-step approach. (Psychiatrist 2). This gap was recognized during social worker training after observing many Somali Muslim individuals seeking addiction services without culturally responsive programs. This experience led to the creation of a Muslim-conscious treatment center, which has been serving the Muslim community since 2015 (Treatment Center Director). The recovery counselor similarly described her own treatment experience, even though it was not an Islamic faith-based program, but the AA program helped her. She recognized that need, which motivated her to become a counselor; now she offers faith-based counseling. Culturally

responsive care for Muslim communities remains limited but necessary. Collaboration between mosques and health care providers is needed to improve culturally responsive care and connect individuals with appropriate services (Imam 1; Imam 2; Psychiatrist 2).

4.8 Summary

The interviews revealed several interconnected themes. Participants acknowledged that addiction exists within Muslim communities but is overlooked frequently due to stigma, shame, and fear of judgment. Individuals and families often delay seeking professional help. Multiple factors, such as islamophobia, trauma, intergenerational gaps, and acculturation, contribute to this issue. Mosques can play a critical role in prevention, especially for youth, by implementing community education, resources for early intervention, and recovery.

In addition to the qualitative interviews presented earlier in this chapter, a mixed-methods approach was used and included a quantitative survey to understand perceptions, experiences, and attitudes related to addiction within Muslim communities. The survey explores several factors, such as awareness of addiction, perceived barriers to seeking help, community attitudes, and the potential role of mosques and healthcare professionals in addressing addiction and mental health concerns among community members.

CHAPTER 5:

QUANTITATIVE DATA REVIEW

5.1 Introduction to Quantitative Findings

This study aimed to collect approximately 100 random responses from members of the Muslim community. A total of 92 participants completed the survey and were included in the analysis. The sample represents a range of community members, including general mosque attenders, community leaders, and health care professionals.

Section	Topic area	Survey Questions
5.2	Demographics	Q1-Q2
5.3	Awareness and understanding of Addiction	Q4-Q8
5.4	Community Attitude and Barrier	Q9-Q11, Q14-Q15
5.5	Role of Mosques	Q12, Q13,Q16
5.6	Prevention and Protective Factors	Q17, Q18
5.7	Healthcare and Faith Collaboration	Q19-Q21

Table 5.1 summarizes the survey categories used in the analysis

5.2 Demographics

Age: The majority of survey respondents were mature adults. Those aged 26–45 represented 48% (n= 40), followed by those aged 46–65 at 38% (n=32). Younger adults aged 18–25 accounted for 13%(n=11) of the total respondents.

Gender: Results show that 64% (n = 54) of respondents identified as female and 36% (n = 30) identified as male. Female respondents were somewhat more represented in the survey sample.

Place of Birth: Participants were asked where they were born. Results show that 76% (n = 64) reported being born outside the United States, while 24% (n = 20) were born in the United States. These findings suggest that a large portion of the survey sample consisted of immigrants.

Community Role: The majority of participants (66%) described themselves as general attendees. 23% identified as healthcare professionals, while 11% reported serving as community leaders or mosque board members. The relatively higher number of healthcare professionals may have influenced the level of awareness and perception of addiction reported, particularly regarding addiction, mental health, and treatment pathways.

5.3 Awareness and Understanding of Addiction

Participants were asked about their general understanding of addiction, its effect on health, and family life. Responses suggest a relatively strong level of awareness within the community, with 32% indicated excellent understanding, 44% reported a moderate understanding of addiction, 20% reported a somewhat limited understanding, while only 4% stated that they were

unsure. These findings suggest that more than 50% of respondents recognize addiction as a significant issue affecting both individuals and families.

Perceived Prevalence of Addiction: Participants were asked about their perceptions of how common addiction is among Muslims. 37% considered it very common, 46% reporte somewhat common. A smaller portion of respondents (15%) believed addiction is rare, and 2% reported that it is not common at all. These results suggest that many respondents acknowledge that addiction exists within Muslim communities.

Exposure to Types of Addiction: Participants were asked about the types of addiction they had personally observed or encountered within the community. A total of 70 participants responded to this question. Cigarette and vaping-related exposure was the most frequently reported (90%), followed by alcohol (54%) and marijuana or cannabis use (43%).

Table 5.2 Personal or indirect exposure to different types of Addiction

Q9 - Personal or Indirect Experience (N = 70)

Response	Percentage (%)	Count (n)
Alcohol	53%	37
Cigarettes or vaping products	89%	62
Gambling	27%	19
Marijuana or cannabis products	41%	29
Prescription pain medications (e.g., opioids) used more than prescribed	26%	18
Prescription stimulant medication (e.g., Adderall) used more than prescribed	23%	16
Sexual or Pornography	46%	32
Street drugs (e.g., cocaine, heroin, methamphetamine)	20%	14

5.4 Community Attitudes and Barriers

Help-Seeking Behavior: Participants were asked where individuals within their community would most likely seek help for addiction. Responses indicate that the majority will not seek help (49%). Among those who do seek help, individuals turn to friends or family members (17%), doctors or healthcare providers (12%), and imams or mosque leaders (5%).

Barriers to Seeking Help: Participants identified several barriers to seeking help. Fear of stigma or judgment was the most commonly reported barrier (93%). Concerns regarding confidentiality within the community (67%, n = 57). Other barriers included lack of culturally sensitive care (53%, n = 44), belief that addiction is a moral weakness (48%, n = 40), lack of awareness of treatment options (42%, n = 53), and financial barriers (27%, n =22). These findings highlight that social and cultural factors significantly influence help-seeking behavior.

Table 5.3 Perceived Barriers to Seeking Help

Q11. Perceived Barriers (N = 85)

Response	Percentage (%)	Count (n)
Fear of stigma or judgment	93%	79
Lack of confidentiality in community	67%	57
Lack of culturally sensitive care	52%	44
Belief addiction is sin/weakness	48%	41
Lack of awareness of treatment	41%	35
Financial/access barriers	26%	22

5.5 Role of Mosques

Support for Mosque-Based Programs: Participants were asked about the role of mosques in addressing addiction education, counseling, or referral services. Participants showed strong support for mosque involvement. 64% (n = 54) strongly agreed with this idea, while 25% (n = 21) somewhat agreed. Another 10% (n = 8) reported they neither agreed nor disagreed, and 1% (n = 1) somewhat disagreed. These results show that mosques are seen as potential spaces for education and support related to addiction by the majority of respondents.

Comfort Discussing Addiction in Mosques: Participants were asked how comfortable they would feel if addiction were discussed in mosques through khutbahs, youth talks, or community seminars. The majority showed strong support (56%, n = 47), followed by moderate support, (30% n = 25). A smaller proportion of respondents reported neutral feelings (13%, n = 11), and only 1% (n = 1) reported feeling somewhat uncomfortable. More than 50% indicated they would be comfortable discussing addiction in a mosque setting.

Mosque Readiness: Participants were also asked to assess how prepared mosques are to address addiction and related mental health concerns. Responses indicate that 10% of participants believe mosques are ready; while 76% (n = 62) reported that mosques are not prepared, 10% reported mosques are somewhat prepared (n = 8), 13% (n = 11) reported that they were unsure. This suggests a gap between community expectations and perceived institutional readiness.

Table 5.4 Mosque Readiness

Q16. Mosque readiness (N = 84)

Response	Percentage (%)	Count (n)
Very prepare	1%	1
Somewhat prepared	12%	10
Not prepared	74%	62
I do not know	13%	11

5.6 Prevention and Protective Factors

Protective Factors: Participants were asked about factors that they believed may help individuals avoid substance use or other high-risk behaviors. Participants were asked to choose all that apply. Personal faith or religious belief was the most frequently identified protective factor, selected by 85% (n = 68) of respondents. Other commonly reported factors included personal boundaries or self-discipline (66%, n = 53) and family values or cultural expectations (63%, n = 50). Additional responses included awareness of health risks (55%, n = 44) and supportive friends or mentors (34%, n = 27). This suggests that in Muslim communities, both religious and social influences may play a role in prevention.

Confidence in Resisting Peer Pressure: Respondents were asked how confident they felt in their ability to resist peer pressure related to alcohol or drug use. The majority reported a high level of confidence, 84% (n = 70) indicated that they were very confident, while 12% (n = 10) reported being somewhat confident. A small proportion, 4% (n = 3), reported being unsure.

5.7 Healthcare and Faith Collaboration

Islamic Psychology Approach: Another question explored perceptions of an Islamically integrated psychological approach to addiction treatment. A majority of respondents viewed this approach positively 60% (n = 50) reported that such an approach would be very helpful, while 27% (n = 22) considered it somewhat helpful. A smaller number reported that it would not be very helpful (6%, n = 5) or stated that they were unsure (7%, n = 6).

Role of Healthcare Professionals in Faith-Based Referral: Participants were asked about their views regarding the role of healthcare professionals in referring patients to faith-based programs. Nearly half of the participants (49%, n = 41) indicated that this role was extremely important. Another 26% (n = 22) considered it very important, while 20% (n = 17) reported that it was moderately important. Only a small number viewed it as slightly important (4%, n = 3) or not important (1%, n = 1).

Conditions for Faith-Based Referral: Finally**,** respondents were asked under what circumstances faith-based programs should be included in addiction treatment. Participants were asked to choose all that apply. Most respondents (73%, n = 62) supported faith-based programs when patients request them. Other participants indicated support when recommended by a physician (40%, n = 34) or when family members prefer such programs (40%, n = 34). Another 34% (n = 28) supported faith-based programs as a supplement to medical treatment. A small number were unsure (7%, n = 6) or believed such programs should not be included (2%, n = 2). This suggests that individual requests are most important, while health care and family play an important rale.

The purpose of this part of the chapter is to present the descriptive results of the community survey. This was intended to examine awareness, attitude, and perceptions regarding addiction within Muslim communities. The findings highlight several key factors, such as community awareness of addiction, attitudes, and perceived barriers to seeking help related to addiction. It also gathers information on attitudes toward the role of mosques not only as religious institutions but as sacred places to educate and help the community. It highlights the healthcare professionals' role in addressing addiction.

In the following chapter, I will integrate the quantitative findings with the qualitative interviews and the existing literature to provide a broader interpretation of the results.

CHAPTER 6:

DATA DISCUSSION AND ANALYSIS

6.1 Introduction

The purpose of this chapter is to examine and interpret the findings presented in Chapter 4 (qualitative) and Chapter 5 (quantitative) by bringing them together into the conversation with one another. The interview data and survey results are consistent in showing that addiction exists in Muslim communities. Stigma, family dynamics, perception of moral failure versus limited understanding of addiction as a medical condition, mental health struggles, and gaps in community response are various dynamics to understand.

The findings in the study align with the literature while also revealing areas of tension within the community. Participants consistently emphasized that the mosque should play a role in addressing addiction and supporting those affected. At the same time, there is concern that these institutions are not fully prepared to respond. While most participants acknowledge the presence of addiction, a minority continued to deny or minimize it. These differences in perception create gaps that are important for researchers and the community to understand.

In this chapter, I will examine several interconnected themes that emerged from the data. It also encourages us to consider the need for more culturally responsive approaches that bridge the gap between faith-based settings and the healthcare system. Understanding how adduction is

perceived and experienced in American Muslim communities is of utmost importance, given their diversity, where shared religious beliefs intersect with varied cultural contexts.

6.2 Addiction Is Present, but often Hidden

One of the most consistent findings of this study is that addiction is present and affects individuals across different socioeconomic, gender, and religious backgrounds. It includes alcohol, marijuana, opioids, methamphetamine, prescription drugs, nicotine, and behavioral addictions. Survey findings support this, with a majority of participants (more than 50%) acknowledging that addiction exists, while only a small minority described it as rare or not present. This challenges the false assumption held by some that addiction is not a Muslim issue.

This pattern is also reflected by prior research. Padela and colleagues found that American Muslims do experience substance use disorders, even if the pattern differs somewhat from that of the general population. They reported lower alcohol use disorder compared to non-Muslims, but similar levels of other substance use disorders and higher tobacco use. Rassool similarly argues that Muslims are not outside the modern addiction landscape exposed to opioids, alcohol, and prescription drugs as everyone else. The national data from SAMHSA and the CDC also support this broader context that American Muslims face the same public health crisis.

Although the number of interview participants was small, they represented diverse backgrounds, including imams, health care professionals, community leaders, and individuals with lived experience. Despite these differences, there was a consistent recognition that addiction in Muslim communities is less visible in other settings. Participants repeatedly used terms such

as hidden, secret, not discussed, and covered up. This hidden nature affects prevention efforts as communities may underestimate its prevalence. Delayed recognition and responses can lead to serious consequences, including legal issues, hospitalizations, or family crises.

6.3 Stigma as a Barrier to Help-seeking and Open Discussion

Stigma emerged as the strongest theme in this study. It appeared consistently across the interview and was clearly reflected in the survey findings. A large majority of respondents, 93% (n = 79), identified fear of stigma or judgment as a major barrier to help-seeking. In addition, 67% (n = 57) reported concerns about confidentiality within the Muslim community. Nearly half of the survey participants, 48% (n= 41), also viewed addiction as a moral or spiritual weakness, further discouraging individuals from seeking support.

Another finding comes from a question asking whether participants had personally experienced or knew someone affected by substance or behavior addiction. This item received responses (75%) out of 94 participants. while 24 participants chose not to answer, making it the lowest response rate among the survey. This pattern suggests that although addiction is recognized within the community, personal or family exposure remains difficult to disclose. Concern about social perception continues to shape what is shared and what remains hidden.

The interviews provide deeper insights into these findings. Participants, including imams and recovery advocates, described how stigma can lead to marginalization, gossip, and damage to family reputation and honor. Concerns about a marriage prospect were frequently mentioned, along with Fear of being labeled immoral or weak in faith. Some participants noted that families

do not deny addiction because they are unaware of it, but because they do not want others to know.

These findings are consistent with the literature. Ciftci, Jones, and Corrigan identify stigma as a major barrier to mental health care in Muslim communities. Awaad and Ali make a similar observation, while Kouser and Raheemullah highlight how concerns about confidentiality prevent families from engaging in support services. The ISPU report reflects the same pattern. At the same time, Hassan and colleagues show that psychoeducation in mosque settings can reduce stigma, suggesting that these barriers are not fixed and can be addressed.

What this study adds is a clearer understanding of how stigma shapes behavior. In the survey, 47% (n= 41) of respondents believed that a person struggling with addiction would likely not seek help at all. This indicates that silence is not only an emotional but also a behavioral issue, leading to delayed care. As a result, addiction is often pushed into improvised spaces, where it can worsen before any intervention occurs, and reduces opportunities for early intervention within the community.

6.4 Addiction is Closely Linked to Mental Health, Trauma, and Stress

The literature review in Chapter 2 showed that addiction often overlaps with mental health disorders in the general population. This places additional pressure on Muslim communities already facing acculturation stress (Muslim identity confusion, gender dysphoria), discrimination (Islamophobia), family conflict, intergenerational gaps, war- related trauma, and other forms of hidden distress. Arfken and Ahmed noted that substance use can increase with longer time spent

in the West. Mallik and colleagues described addiction as an “undercover problem” in Muslim communities. Bassioni and Langrehr, as well as Abu-Ras and Suarez, show that mental health burden is often shaped by discrimination and fear. These broader pressures help explain why some youth may use substances to manage pain, stress, or a sense of belonging.

Survey findings support this connection. More than half, 69% (n = 57) of respondents strongly agreed that mental health challenges such as anxiety, depression, or trauma can contribute to addiction or make recovery more difficult, while another 25% (n = 20) somewhat agreed. Very few participants were neutral.

The interview data give this theme a more personal dimension. Several clinicians described that addiction may begin as a result of undiagnosed or untreated mental health conditions. Many Muslim youth do not initially present with addiction, but instead seek help for depression, ADHD, anxiety, trauma, or other psychiatric symptoms, with substance use becoming apparent later. One interviewee specifically emphasized the importance of addressing underlying mental health issues early. When early emotional struggles are missed by parents, imams, or schools, substance use may also go unrecognized.

Several interviews, including those with imams, emphasized the importance of youth-focused and family-based education programs. For mosque-based care, this means that addiction education and support cannot be separated from conversations about trauma, depression, and anxiety among Muslim youth. These interconnected issues require a more integrated approach, which will be discussed further in Chapter 7.

6.5 Family can be Protective, but they can also Delay Care

Islam is a communal religion; family and friends, wider communities play vital roles in one's life. Family emerged as another theme in the study. In the data, its role was complex. In many cases, family members could be first responders but lack the tools to fully help someone struggling with addiction. Family can be supportive or hinder treatment during recovery.

The survey portrayed this complexity. When asked where people would most likely seek help, only 12% (n = 10) chose doctors or healthcare providers, 5% (n = 4) chose imams or mosque leaders, and 19% (n = 16) chose friends or family. 49% (n = 41) believed the person would not seek help. This suggests that addiction is often handled privately, informally, or not at all.

The interviews provide further insight into this dynamic; several participants share examples and experiences showing that family is often the first place people turn for help when facing mental health issues or addiction. At the same time, complex family dynamics, intergenerational gaps, and untreated mental health issues, often shaped by cultural perception, can make the situation more difficult. One recovery counselor noted the challenges faced by Muslim female patients in completing extended outpatient treatment. Both recovery advocates and imams emphasize family education in supporting effective care.

6.6 Mosques aree Seen as Important, but Most Are Not Ready

There is an important tension in this study regarding mosque involvement, alongside concerns about the current capacity. When asked about the mosque-based educational program

for addiction, the participants showed strong support. 64% (n = 54) strongly agreed, 25% (n = 21) somewhat agreed, 10% (n=8) neither agreed or disagreed, 56% (n = 47) said they would be extremely comfortable if addiction were discussed in khutbahs, youth talks, or seminars, and 29% (n = 24) said they would be somewhat comfortable.

At the same time, 76% (n = 62) said mosques are not prepared to address addiction and related mental health concerns. Only 1% (n = 1) believed mosques are very prepared. While community members desire an active involvement of mosques, they also recognize that mosques are not adequately equipped. Out of 85 respondents who reported their role, 19 identified as healthcare professionals. Their presence in the sample may have influenced the perception of mosque capacity. As individuals with clinical or healthcare backgrounds, they may be more aware of the complexities involved in addressing addiction.

This is supported by the literature. Abu-Ras, Gheith, and Cournos showed that imams are often approached for counseling and crisis support, even without formal training. Padela and colleagues found that Muslim communities expect imams to address health and mental health concerns, whether or not they are prepared. Mallik and colleagues found that imams recognize addiction in the community but are uncertain about best practices and referral systems. Ansary and Salloum also note that imams are important resources but should not be expected to function as clinicians.

6.7 Faith Matters, but "Just Pray More" is Not Enough

Clinicians strongly cautioned against advising a person to "pray more" without appropriate clinical help. Participants expressed that this approach may cause further harm. The concern is not with prayer itself but with using prayer as the only response, in place of professional assessment and treatment. These findings suggest that faith and professional treatment should not be seen as competing approaches. Many participants actually endorse it as a helpful part of prevention. The clinicians expressed that faith can support healing. The child and adolescent psychiatrist especially warned that moral warnings without understanding a young person's stressors can lead to more withdrawal and silence.

The survey responses showed strong support for faith-sensitive care. 60%(n = 50) said an Islamically integrated psychological approach would be very helpful, and 27% (n = 22) said it would be somewhat helpful. These findings are supported by the literature on spiritually integrated care. Rassool argues that Muslim addiction treatment should not ignore the spiritual dimension of suffering and recovery. Keshavarzi and colleagues warn that mainstream treatment often feels too secular for Muslim clients, even when clinically sound. Koenig's work on religion and health also supports the value of spirituality as a coping resource.

Taken together, these findings suggest that faith and treatment should not be understood as competing approaches. Rather, they may function most effectively when integrated in complementary ways. Spiritual practices can provide meaning, motivation, and moral grounding during recovery, while clinical treatment addresses the biological and psychological dimensions

of addiction. When these elements are combined thoughtfully, they may create a holistic pathway for healing.

6.8 The Need for Culturally Responsive and Collaborative Care

A final major issue identified in the data is the need for culturally responsive care. Survey respondents named this directly, 53% (n = 44) identified a lack of culturally sensitive care as a barrier to treatment. This finding matches the literature. Rassool and Keshavarzi argue that treatment that ignores faith and culture may lead to weak engagement or early dropout from care.

Cultural responsiveness also influences trust in treatment systems. When patients feel that clinicians understand their cultural background, religious beliefs, and family dynamics, they may be more willing to engage in treatment and remain in care. Conversely, when treatment environments feel unfamiliar or culturally disconnected, individuals may hesitate to seek help even when services are available. These findings highlight that culturally responsive care is not an optional addition but a necessary part of effective treatment. For many individuals, feeling understood in their faith, culture, and family context can make the difference between seeking help or remaining silent. This further supports the need for collaboration between clinicians, community leaders, and mosques to create pathways of care that are both clinically sound and culturally meaningful.

6.9 Conclusion

Overall, the findings highlight both concern and opportunity within Muslim communities. Addiction is present and often shaped by stigma and fear of judgment, delayed recognition, and barriers to care.

At the same time, many mosques are already responding in meaningful ways. Imams are speaking about addiction in sermons, youth programs, and community discussions, while others provide informal counseling, support families, or help connect individuals to care. In several cases, these efforts emerge from the direct needs expressed by congregants rather than from formal training or structured institutional programs. However, these efforts are not consistent. Many communities still struggle with limited resources, a lack of training, and hesitation to address it openly. In some areas, community leaders are actively seeking partnerships with healthcare professionals, while in other settings, stigma and cultural concerns continue to limit open discussion. Several participants noted that mosque leadership often carries the responsibility of responding to these issues without formal mental health training, clear referral pathways, or institutional resources.

Overall, the findings point to a clear need for stronger collaboration between mosques, healthcare providers, and community organizations. Rather than expecting mosques to function as treatment centers, many participants suggested that mosques can play a vital role in prevention, education, stigma reduction, and referral to professional services. Such partnerships help bridge the gap between spiritual guidance and clinical care. Chapter 7 builds on the insights from the interviews, survey findings, and existing literature to propose a practical mosque-based

model for prevention, support, and referral that seeks to respond to this reality with honesty, compassion, and theological depth.

CHAPTER 7

A Practical Mosque-Based Model for Prevention, Support, and Referral

7.1 Introduction

The previous chapters of this study showed that addiction exists in Muslim communities but often remains hidden due to stigma, fear of judgment, and limited culturally responsive resources. Interviews with clinicians, community leaders, and religious leaders revealed that many families struggle privately before seeking professional help. Participants emphasized the importance of mosques as the most trusted institutions in Muslim communities. Families frequently approach imams when personal crises arise.

The purpose of this chapter is to translate the findings of this study into a practical framework that mosques and community organizations can use to address addiction and mental health concerns. A four-stage model is proposed for mosque engagement in addiction prevention and recovery. The model focuses on prevention, early support, referral to professional care, and community-based recovery support. This approach recognizes that reducing stigma requires discussion from prevention to recovery and requires a community ecosystem. Mosques, healthcare providers, community organizations, families, and peer networks each contribute different forms of support. When these actors collaborate, Muslim communities can recover..

7.2 The Mosque-Based Prevention, Support, and Referral Model

A four-stage model is proposed for mosque engagement in addiction prevention and recovery. The model focuses on prevention, early support, referral to professional care, and community-based recovery support. The stages of this model are outlined in Figure 7.2.

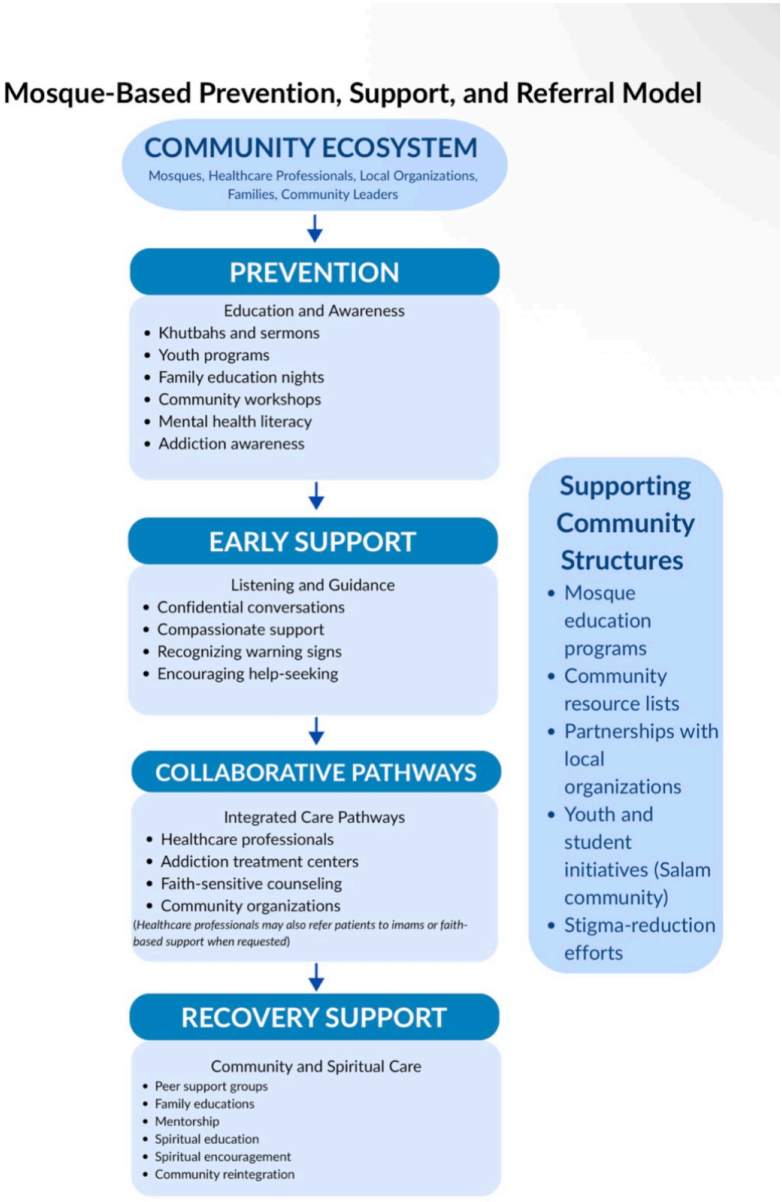

Figure 7.2: Mosque-Based Prevention, Support, and Referral Model

Guiding Principles of the Mosque-Based Response Model

The mosque-based prevention, support, and referral model discussed earlier is guided by several key principles that emerged from the interviews, survey findings, and the broader literature discussed earlier in this study.

1. Compassion and Non-Judgment: Addiction should be approached with compassion rather than stigma. Study emphasizes that individuals struggling with addiction often fear judgment from their communities. A supportive and non-judgmental environment encourages individuals to seek help earlier. Research on mental health stigma in Muslim communities shows that fear of social judgment and community reputation often delays help-seeking behavior.

2. Collaboration Rather Than Isolation: Mosques cannot address addiction alone. Effective responses require collaboration between religious leaders, healthcare professionals, and community organizations. The model emphasizes referral pathways and partnerships rather than expecting mosques to provide clinical treatment. Research highlights the importance of collaboration between mosque leadership and professional healthcare systems when addressing complex mental health challenges.

3. Early Recognition and Support: Early conversations and supportive guidance can help prevent addiction problems from becoming more severe. Imams and community leaders serve as first points of contact for individuals and families experiencing emotional distress or behavioral concerns. Studies of mosque leadership show that community members frequently approach religious leaders before seeking formal mental health services.

4. Integration of Spiritual and Clinical Care: Faith and spirituality can support recovery, but they should complement—not replace—professional addiction treatment. Integrating spiritual support with evidence-based healthcare helps individuals feel understood and supported throughout recovery. Islamic psychology and spiritually integrated therapy emphasize that addressing both spiritual and psychological dimensions of distress can improve engagement in treatment among Muslim patients.

5. Community Reintegration: Recovery involves more than abstinence from substances. Individuals need continued social support, mentorship, and opportunities to rebuild stability within their communities. Mosques can provide environments where individuals in recovery feel welcomed and supported, reducing isolation and encouraging long-term recovery.

7.3 Prevention Through Community Education

The first component of the model focuses on prevention through community education. One of the most significant barriers was stigma surrounding addiction and mental health. Families avoid discussing these issues because they fear community judgment. Mosques can integrate addiction awareness into existing programming rather than creating entirely new structures. Imams address addiction and mental health in sermons by emphasizing compassion, accountability, and the importance of seeking help.

These discussions help shift community perceptions from moral condemnation toward understanding addiction as a treatable condition. Examples of prevention activities include:

- Khutbahs and sermons addressing addiction and mental health

- Youth discussions and workshops address topics such as peer pressure, substance misuse, and coping with stress. Youth-led discussions may also help normalize conversations about mental health.
- Family education nights: Family programs guide parents on recognizing warning signs and supporting children facing emotional distress.
- Community seminars: Mosques may host seminars featuring clinicians, addiction specialists, or individuals in recovery who are willing to share their experiences. This will encourage open communication.

7.4 Early Support and Listening Pathways

The second stage of the model focuses on early support. When individuals or families approach mosque leaders, they seek guidance before pursuing professional treatment. Imams and trusted community leaders play an important role by providing compassionate listening and encouraging individuals to seek appropriate care. Participants emphasized that imams should not be expected to diagnose or treat addiction. Instead, their role is to listen, offer spiritual support, and guide individuals toward professional resources.

One psychiatrist, who was interviewed, suggested that mosque leaders may benefit from visiting local addiction treatment centers. Such visits help imams understand how treatment facilities operate and reduce uncertainty when referring community members to these programs. These types of relationships strengthen collaboration between mosques and healthcare providers.

7.5 Collaborative Referral Networks

A central finding was the need for clear referral pathways connecting mosques with healthcare professionals and community organizations. Mosques develop simple referral lists that include:

- Addiction treatment centers

- Mental health professionals

- Culturally responsive counseling services

- Community recovery programs

- Crisis support services

These resources are shared in multiple ways so that individuals can access help even if they do not feel comfortable discussing their situation directly. For example: Resource lists on mosque websites, Mental health information in community newsletters, Educational posts on mosque social media pages. Providing accessible information allows individuals to seek help privately when needed. Local community organizations may also serve as important partners in providing counseling services, addiction treatment programs, and social support.

7.6 Recovery Support and Community Reintegration

Recovery does not end when treatment begins. Individuals benefit from continued community support during recovery. Mosques create environments that support recovery through mentorship, peer support, and social inclusion. Possible initiatives include:

- Peer support groups offer safe spaces where individuals facing addiction challenges can discuss their experiences confidentially.
- Recovery speakers, Individuals in recovery who are comfortable sharing their stories, may speak at community events to reduce stigma and inspire others.
- Gender-specific support groups providing separate spaces for men and women may help create environments where individuals feel comfortable discussing sensitive issues.
- Youth peer mentorship through Youth-led programs that support younger community members and promote healthy coping strategies.

Mosques already operate programs that support families facing financial hardship, such as rent assistance or food support initiatives. Similar structures adapted to support individuals recovering from addiction. For example, community recovery networks provide: Job search assistance, Mentorship opportunities, Educational support, and Weekly or monthly recovery meetings. Such programs help individuals rebuild stability and reconnect with community life after treatment. These efforts reflect a broader understanding that addiction recovery involves not only medical treatment but also social reintegration.

7.7 Youth and Student Support Spaces

Young adults face unique pressures related to academic expectations, social identity, financial stress, and discrimination. Participants noted that university-aged Muslims may experience isolation or identity conflict while navigating these challenges.

In response to these concerns, the author and two colleagues seek to provide programs focused on mental well-being, peer support, near the University of Minnesota, aimed at creating a supportive “third space” for Muslim students and young adults. The initiative is referred to as the Salam Community Project. The project aims to create an environment where students can discuss mental health concerns, identity challenges, and social pressures in a culturally sensitive setting. While still in development, initiatives such as this illustrate that community spaces outside traditional mosque structures may complement mosque programming by addressing the needs of younger generations.

7.8 Implementation Considerations

Although the model offers practical strategies, implementation will vary across communities. Mosques differ widely in resources, leadership structures, and community readiness to discuss addiction. Some communities initially resist open discussion of addiction due to concerns about stigma or reputation. Educational programs need to begin gradually, focusing first on mental health awareness and family support.

Despite these challenges, many participants in this study expressed optimism that communities are becoming more willing to address these issues. Continued collaboration

between mosques, healthcare professionals, and community organizations helps strengthen these efforts over time. In addition to the initiatives described above, the author intends to continue working with community partners to strengthen access to addiction and mental health resources within Muslim communities. This includes compiling and maintaining updated lists of culturally responsive clinicians, addiction treatment programs, and community organizations that can serve as referral options for mosques and community leaders. Efforts also include sharing educational materials, facilitating collaboration between healthcare professionals and religious leaders, and supporting community discussions that reduce stigma surrounding addiction and mental health. While these efforts remain ongoing and will require collaboration with many stakeholders, they reflect a broader commitment to translating the findings of this research into practical community support structures.

7.9 Summary

This chapter presents a practical mosque-based model for addressing addiction through prevention, early support, referral networks, and recovery support. The model emphasizes collaboration between mosques, healthcare professionals, and community organizations. Rather than replacing clinical treatment, mosques can function as trusted community spaces that reduce stigma, encourage help-seeking, and provide supportive environments for individuals and families affected by addiction. Drawing on survey data, interviews, and earlier literature, the model highlights four key areas:

- Prevention through education
- Early supportive conversations

- Referral to professional services
- Continued recovery support

Collaboration is essential. This partnership requires ongoing feedback between mosques, healthcare professionals, families, and organizations. I hope that through education, supportive guidance, and referral networks, mosques can help create more compassionate and informed community responses to addiction and mental health challenges. The next chapter concludes the study by summarizing the major findings, discussing the limitations of the research, and reflecting on future directions for addressing addiction in Muslim communities. Regardless of the challenges, most participants remained positive in the belief that communities will be more willing to address these concerns. The participants hope that there will be increased collaboration among mosques, healthcare professionals, and community organizations in order to solidify these efforts.

Additionally, efforts can be made to continue working with partners to make access to mental health and addiction resources more attainable. These efforts include maintaining and collecting lists of identity-affirming clinicians, addiction treatment programs, and organizations in communities that will serve as referred resources for mosques and community leaders. These efforts extended to non-muslim or traditional health care systems, making resources feasible for everyone. The Salam initiative also provides many healthcare professionals and religious leaders who are very open to supporting the community's capability of reducing stigma surrounding mental health and addiction, and collaborating with those in need of help.

CHAPTER 8:

DISCUSSION AND CONCLUSION

8.1 Introduction

In this final chapter of my research, I will express my gratitude to the extraordinary people who were willing to share their experiences and perspectives to improve the world in which we live. Regardless of whether you are an Imam, a healthcare provider, a leader working to assist individuals with relapse daily, or a survivor of recovery, your strength is far more than the science, data, or interpretation of the studies I conducted, and the surveys completed by members of the Muslim Community. The Islamic tradition itself encourages us to honor such people. The Prophet Muhammad (ﷺ) stated,

The most beloved of people to Allah are those who are most beneficial to people." (Al-Mu'jam al-Awsat, al-Tabarani, No. 6026; graded hasan by al-Albani in al-Silsilah al-Sahihah, No. 906)

Addiction is not nonexistent in Muslim Communities; however, when addiction occurs in the Muslim Community, it is often concealed, minimized, or not addressed until the issue reaches an extreme level. At the same time, the results of this research project also indicate that there are many Muslim Communities that are interested in addressing the issue of addiction and are looking for a more comprehensive response to the issue. Unfortunately, many of these communities lack organized systems of prevention, education, referrals, and support for recovery.

Working as a primary care physician, I see patients struggle with mental health. Many of these patients experienced a range of psychological disorders, which include depression, anxiety,

trauma, and emotional distress. In my own clinical practice, I see both the long-term and short-term effects of mental health on an individual's quality of life, their relationship with their family and friends, and their ability to abstain from using substances. I also see the effects of mental health on a patient's use of substances, especially the use of prescription pain medicine.

Although I have extensive knowledge regarding the diagnosis and treatment of the various forms of mental health disorders, the ongoing education and the long-term impact of addiction in general, but not within the Muslim community. Through the interviews conducted during this research project, I gained a greater personal awareness of the scope of addiction in the Muslim community. Hearing from clinicians, Imams, treatment providers, and most importantly, individuals in recovery, gave me an awareness that addiction is not just a statistic in the field but a lived reality. Addiction represents actual people, and their families, who face actual pain and long battles that are frequently fought in silence.

8.2 Reframing Addiction: Presence, Visibility, and Denial In Muslim Communities

One consistent finding emerged: addiction exists in Muslim communities; however, it is often hidden. Clinicians, community leaders, and Imams all reported seeing addiction in Muslims in the form of alcohol use, marijuana, opioids, methamphetamine, prescription abuse, nicotine, and behavioral addiction.

Many respondents acknowledged that addiction is present in the community, though it is rarely openly discussed. This is an important finding because it contradicts the prevailing notion that religious proscription alone is responsible for preventing the community from engaging in addictive behaviors.

According to my study, what differentiates Muslim communities is not the presence of addiction, but the likelihood that addiction remains hidden. Similar findings have been described in Islamic medical literature, where addiction is often minimized primarily as a spiritual weakness, which leads to avoiding addressing underlying psychological issues. Several participants reported to me that families often endure the struggles of addiction for months or years before seeking professional assistance. In some instances, the manifestations of addiction do not become evident until a serious medical emergency occurs, often becoming visible only during a crisis. This is especially disturbing, considering the Prophet's (ﷺ) explicit command to seek treatment:

"Seek treatment, for God has not created a disease without creating a remedy for it." Sunan Abi Dawud, No. 3855; Sahih al-Tirmidhi, No. 203

As the recovery therapist recalled the loss of her niece to an overdose, and how her family attributed her death to a heart attack. Her account exemplifies how stigma persists even after death. It also demonstrates that addiction does not only impact the immediate struggles of the person abusing substances; it also impacts how families grieve, how communities recount the narratives of their suffering, and how suffering is memorialized or erased.

8.3 Stigma as a Structural Barrier to Help Seeking

Stigma emerged as the central theme of this study. Participants described that the fear of exposure and damage to family reputation would negatively impact them if their addiction became public. When addiction is seen as primarily a source of shame, weakness, or moral failure, individuals and families are less likely to seek help at the earliest stages of addiction.

Instead of seeking help, conceal or delay help seeking. Several participants reported that families sometimes depend on religious counsel or family management, and/or secrecy until the situation worsens. It delays treatment. It isolates the individual suffering from addiction. It deprives parents of guidance, and it leaves siblings without the means to articulate what they observe. It also causes imams, clinicians, and community leaders to react to addiction late instead of early. However, the findings of the study also indicate that stigma is not static. Participants repeatedly emphasized that communities could reduce stigma through education, open communication, compassionate terminology from a religious standpoint, and overt acknowledgment that addiction is a legitimate condition that requires care.

The Quran perhaps contains the most potent antidote to the despair that suppresses people from speaking and seeking help:

"Say: Oh, my servants who have acted in excess against yourselves, do not lose hope in the mercy of God. For God forgives all sins." (Quran 39:53)

When mosques discuss addiction using the language of mercy, accountability, and healing, the discussion evolves. This is one of the most positive findings of the study. The problem is deeply hidden; however, it is not beyond solution.

8.4 Interconnection of Addiction and Mental Health: Implications of Care

One further significant finding of this research was that addiction rarely occurs separately from other forms of mental health disorders. In many cases, addiction appears to be a co-existing mental health condition, psychosis, bullying, social isolation, conflicts of identity, and several other stressors. This was observed in the accounts of psychologists and treatment providers interviewed during the study. Many stated that some Muslim patients would first seek out

treatment for depression, trauma, ADHD, and psychosis, and that after the assessment, the presence of substance use would be identified. For me as a physician, this part of the study spoke to me on a deep and personal level. Frequently, in primary care, I see patients experiencing emotional pain that is not immediately apparent. At times, some of my patients will describe their symptoms as headaches, insomnia, fatigue, body pain, irritability, panic, or unexplained distress. Over time, deeper issues may develop.

I found the story of the Somali Muslim recovery worker especially moving. The way she told her story did not begin as a straightforward tale of making poor decisions. Her journey with addiction started with trauma in early life. Later, the temptation of alcohol to deal with distress and to gain confidence socially increased. Her journey lasted for many years, included numerous different treatments, legal repercussions, depression, anxiety, PTSD, shame, and feelings of being disconnected spiritually. However, the last part of her story ultimately evolved into a story of survival, recovery, hope, and purpose.

Listening to her account made it very difficult for me to picture someone struggling with addiction strictly in terms of data and classifications. Instead, it was clear to me that many of those who struggle with addiction are not just data entries in a computer database. Rather, they are often the abandoned, marginalized, forgotten, and silenced members of our society who deserve compassion, structure, and support.

8.5 Youth Vulnerability and the Need for Prevention and Early Intervention

Participants in the interviews reported that they had found that youth and young adults experienced intergenerational gaps, acculturative stress, peer pressure, academic expectations, bullying, family conflict, internet and social media exposure, isolation, and conflict of identity to

be among the pressures they experience. The study's findings are consistent with previous studies and research referenced, and were corroborated by clinicians who have worked extensively with children, adolescents, and young adults.

Youth may be particularly vulnerable when they experience conflicting expectations from their families, and from outside their families, and they may feel as though they are living between two worlds and therefore do not identify with either world. Additionally, youth may conceal their emotional distress from their parents due to fear of punishment, shame, or misinterpretation. Under these conditions, substances may represent a way for youth to cope with distress, numbness, belonging, or escape. Therefore, prevention of addiction cannot wait until serious addiction develops. It must happen sooner through engagement of youth, education of parents, creation of emotionally safe environments, and through discussions that reflect the reality of the experiences of youth. When the community only addresses addiction once the crisis has developed, it will always respond too late.

8.6 Mosques as Entry Points: Potential and Structural Limitations

The role of mosques is central in the Muslim community. Many of the survey respondents stated that they believed the mosques should be involved in education, prevention, and referrals. However, the study also found that the responses of mosques to the issue of addiction are varied. Some Imams and community leaders are currently doing the needed work. They are engaging with families, addressing addiction-related issues in their youth programs and community events, referring to existing resources, and responding with compassion. Some communities have developed relationships with clinicians, counselors, or organizations

specializing in Muslim mental health. Additionally, several Imams have expressed interest in attending training and developing better working relationships with clinicians.

However, most mosques lack formal training, established referral systems, and ongoing support networks. Participants in this study indicated that Imams are often called upon to address addiction and mental health issues without adequate training. Participants also indicated that there are often no mechanisms in place, such as confidential referral systems, community resources, lists of culturally competent clinicians and mental health services, and peer support structures, to assist individuals once they reach out to the mosque for assistance. In no way does this suggest that mosques are failing. Instead, it indicates that many are being asked to assume responsibilities they were never formally trained to fulfill. The findings of this study indicate that mosques can serve an invaluable role in assisting individuals struggling with addiction; however, they cannot accomplish this task independently. Furthermore, mosques should not be expected to operate as treatment centers. This study suggests that while mosques are trusted institutions, they cannot function as standalone treatment centers. Their most effective roles lies in early identification, stigma reduction, and structural referral pathways, support of individuals in recovery, and reintegration into the community.

8.7 The Need for Comprehensive Collaborative Care

Through this research, I wish to contribute to the field by proposing a community-based, faith-informed framework that integrates spiritual care with a clinical referral system, addressing a critical gap in culturally competent addictioncare with in muslim communities. Treatment of addiction in Muslim communities requires collaboration. No single entity or organization can adequately treat the entire problem. Clinicians can provide medical, psychological, and

therapeutic interventions. Mosques can reduce stigma associated with addiction, provide spiritual support, encourage individuals to seek help, and establish safe entry points for care. Schools can establish a supportive environment for students, educate students about the dangers of substance abuse, and establish early intervention strategies. Recovery support networks and other community-based organizations can provide education, case management, recovery coaching, and support for the individual returning to his/her family and community. Participants emphasized that Imams must understand how to obtain care for their congregants, and several proposed that mosque leadership should visit treatment centers and learn about addiction recovery programs. Participants emphasized that communities need lists of culturally competent clinicians, mental health, and addiction treatment services that can be obtained privately and safely. This study also shows that faith is important, but that faith is insufficient to satisfy the need for care when it is used as a substitute for treatment. Prayer, tawbah (repentance), hope, and reconnecting with Allah can greatly benefit the process of recovery. Numerous scholary work in Islamic literature support an integrated model in which spiritual care is combined with medical treatment and therapy. This integration is important rather than viewed as a substitute for it.

8.8 My Final Reflection

After my research, this study suggests future initiatives must focus on developing education and prevention programs, enhancing referral systems, and cultivating culturally sensitive recovery support in Muslim communities. The recovery stories and professional interviews contained in this study clearly demonstrated that individuals affected by addiction are not simply numbers, failures, or cautionary tales. More commonly, they are marginalized,

hidden, and misunderstood members of our society who desperately need compassion and meaningful support. This problem is deeply rooted, but with intentional effort, it is not beyond solution.

If there is one contribution that this study can make, I would hope it is that Muslim communities will begin to move in the direction of greater honesty, preparedness, and mercy. As one Imam stated during an interview,

"This is the reality that is thrust upon us, and we cannot ignore it."

Appendix A: IRB Proposal Approval

Your IRB proposal

VE

Vogt, Emily
To You and Jibril Latif

Feb 13

Hi Shazia,
Thank you for the resubmission of your IRB documents. I'm happy to report that your research is **approved** by the IRB committee. We wish you all the best with your research and thesis.
Warm regards,
Emily

Emily Vogt, PhD
Chicago Theological Seminary
Academic Dean and Vice President for Academic Affairs
Assistant Professor of Anthropology and Ethnography

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Appendix B

Survey Instrument

Ethical Reminder for survey questionnaire:

Participation is voluntary, anonymous, and confidential. You may skip any question. No identifying information is collected.

Survey Title: Addiction in Muslim communities: Understanding perception and Attitudes Toward Addiction Among Muslim Adults

Eligibility: Muslim adults, 18 years and older.

Purpose: This anonymous survey explores community awareness, experience, and attitudes toward addiction and substance use within Muslim communities.

Instructions: Your responses are confidential. Please answer honestly. Check one answer per question.

Do you consent to participate in this survey? (Select one)

□ Yes

□ No

Demographics

What is your age group? (Select one)

□ 18–25

□ 26–45

□ 46–65

□ 66 or over

Gender:

□ Male.

□ Female

□ Prefer not to say

Where were you born?

□ United States

□ Outside the United States

Community role (if applicable):

□ Imam

□ Community leader

□ Health professional

□ General attendee

Awareness and Understanding

How would you describe your understanding of addiction (chemical or behavioral) and its effects on health and family life?

□ Excellent understanding □ Moderate understanding □ Limited understanding □ I’m not sure

Perceived Prevalence

In your opinion, how common is addiction (alcohol, drugs, gambling, pornography, etc.) within Muslim communities in the U.S.?

☐ Very common ☐ Somewhat common ☐ Rare ☐ Not at all ☐ I don't know

Have you ever personally struggled with, or known someone (family/friend) who struggled with, any of the following? (Check all that apply)

☐Alcohol use ☐ Marijuana or other drugs ☐ Prescription medication misuse ☐ Cigarette or vaping addiction ☐ Gambling ☐ Sexual or pornography addiction ☐ None of the above

Attitudes Toward Help-Seeking

If someone in your mosque or community was dealing with addiction, how likely is it that they would seek help from any of the following?

Possible Source of Help	Very Likely	Somewhat Likely	Unlikely	Not at All	Don't Know
Family or friends	☐	☐	☐	☐	☐
Imam or mosque leader	☐	☐	☐	☐	☐
Doctor or healthcare provider	☐	☐	☐	☐	☐
Therapist or counselor	☐	☐	☐	☐	☐
Online or anonymous group	☐	☐	☐	☐	☐

Perceived Barriers

What do you believe are the main reasons Muslims hesitate to seek help for addiction? (Select up to two)

□ Fear of stigma or judgment

□ Lack of confidentiality in the community

□ Lack of culturally sensitive care

□ Belief that addiction is purely a sin or moral weakness

□ Financial or access barriers

□ Lack of awareness about treatment options

6. Mosque-Based Programs

Would you support your mosque offering educational workshops or confidential counseling/ referral services for addiction?

□ Yes, definitely □ Possibly □ Not sure □ No

Openness to Discussion

How comfortable would you feel if your mosque addressed addiction during a Friday khutbah, youth talk, or family seminar?

□ Very comfortable □ Somewhat comfortable □ Uncomfortable □ Strongly opposed

Awareness of Mental Health Connection

Do you believe mental health challenges such as anxiety, depression, or trauma contribute to addiction or make recovery harder?

□ Strongly agree □ Agree □ Not sure □ Disagree

Mental Health in the Community

Have you observed symptoms such as stress, sadness, or anxiety in yourself or someone you know who also struggled with addiction?

□ Yes, frequently □ Sometimes □ Rarely □ Never

Awareness of Community Impact

Have you ever heard of a case in your community where addiction led to serious harm or death (such as overdose or an accident)?

□ Yes □ No □ Prefer not to say

Mosque Readiness and Support

In your opinion, how prepared are mosques to address addiction and related mental health issues?

□ Very prepared □ Somewhat prepared □ Not prepared □ I don't know

Protective and Preventive Factors

If you have ever been exposed to situations involving drugs, alcohol, or high-risk behaviors, which of the following do you feel helped you avoid or resist them?

□ Personal faith or religious beliefs

□ Family values or cultural expectations

□ Personal boundaries or self-discipline

□ Supportive friends or mentors

□ Awareness of health risks

□ Other (please specify):

Confidence in Resisting Peer Pressure

How confident do you feel in your ability to decline peer pressure if offered drugs, alcohol, or invited into high-risk behavior?

□ Very confident □ Somewhat confident □ Unsure □ Not confident

Perceived Helpfulness of an Islamic Psychology Approach

In your opinion, how helpful can an Islamically integrated (faith-based) psychological approach be for Muslims struggling with substance use or behavioral addictions?

(Select one)

○ Very helpful

○ Somewhat helpful

○ Not very helpful

○ Not helpful at all

○ Unsure / need more information

Role of Healthcare Professionals in Faith-Based Referral In your opinion, how important is it for healthcare professionals (e.g., psychiatrists, psychologists, primary care providers) to

consider referral to faith-based programs when treating Muslim patients with addiction or mental health concerns?

(Select one)

○ Extremely important

○ Very important

○ Moderately important

○ Slightly important

○ Not at all important

Conditions for Faith-Based Referral

Under what circumstances should faith-based programs be included in a person's treatment plan?

(Select all that apply)

□ When the patient requests it

□ When recommended by a physician

□When the family prefers it

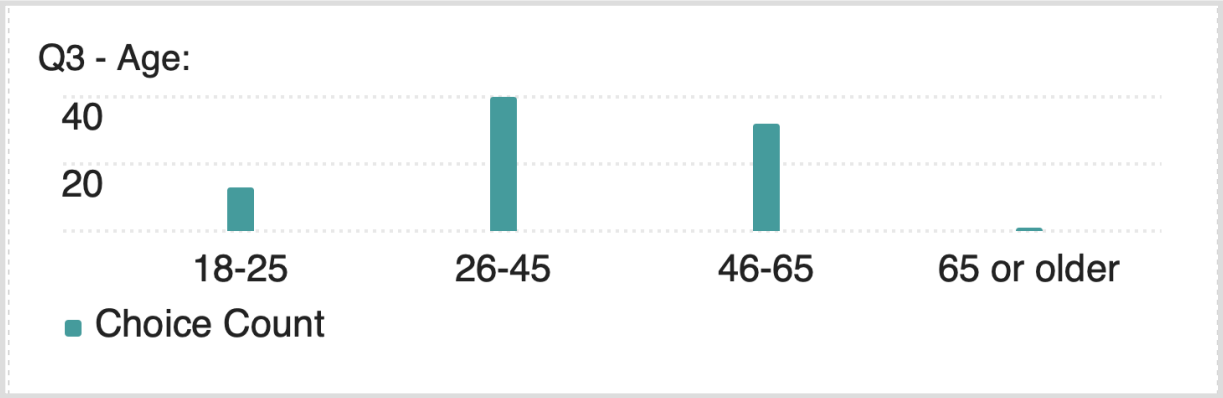
□ Only as a supplement to medical treatment

□ Faith-based programs should not be included

□ Unsure

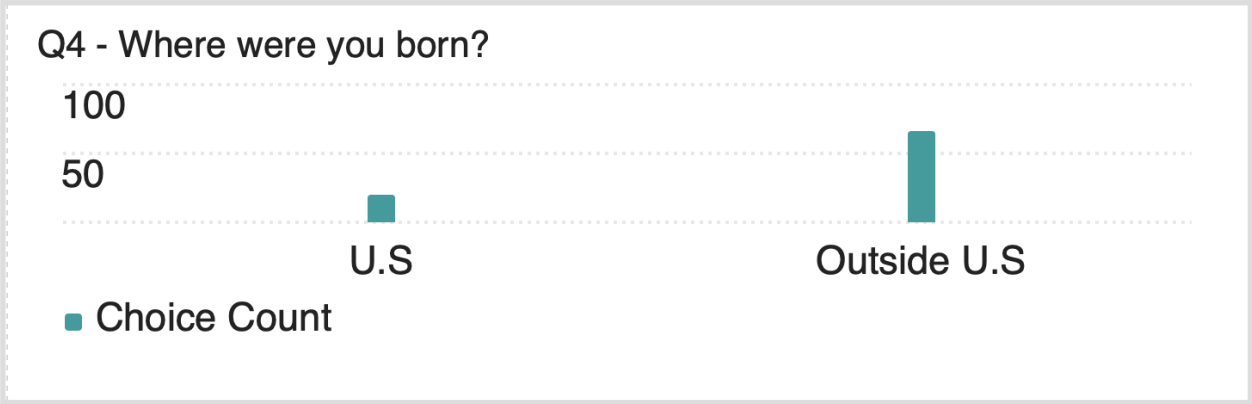
Appendix C

Survey and Data Collection



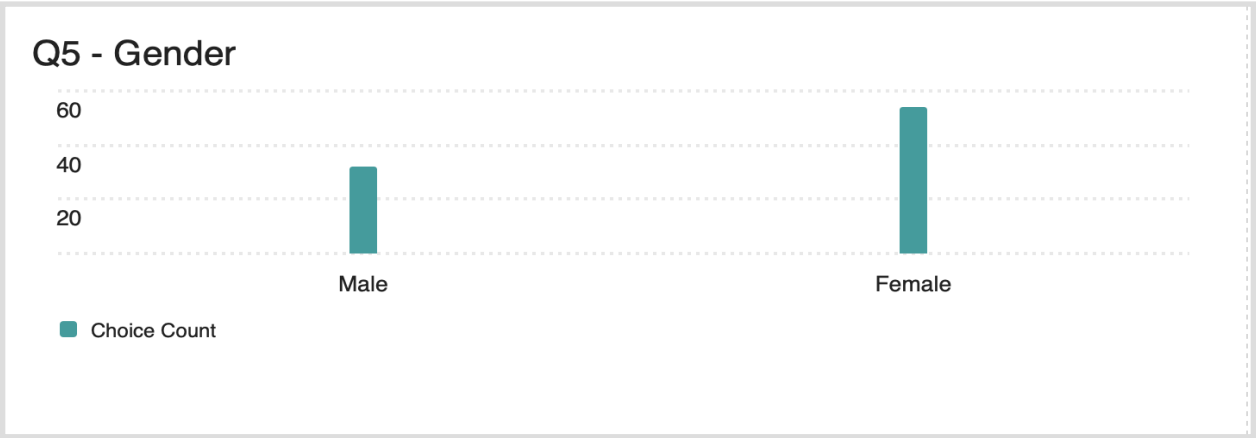
Q3. Age Distribution of Participants (N = 86)

Age Group	Percentage (%)	Count (n)
18–25	15%	13
26–45	47%	40
46–65	37%	32
65 or older	1%	1



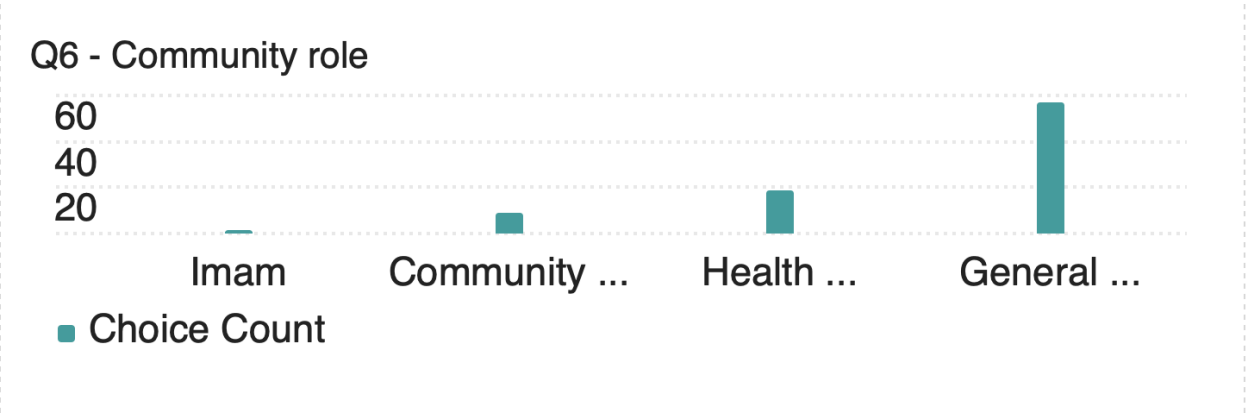
Q4. Where were you born? (N = 86)

Response	Percentage (%)	Count (n)
U.S	23%	20
Outside U.S	77%	66



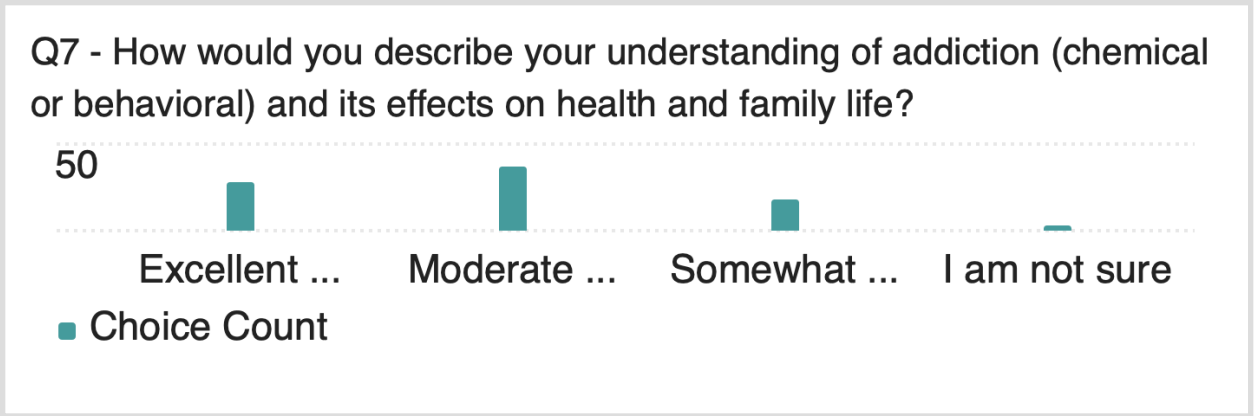
Q5. Gender (N = 86)

Gender	Percentage (%)	Count (n)
Male	37%	32
Female	63%	54



Q6. Community role (N = 85)

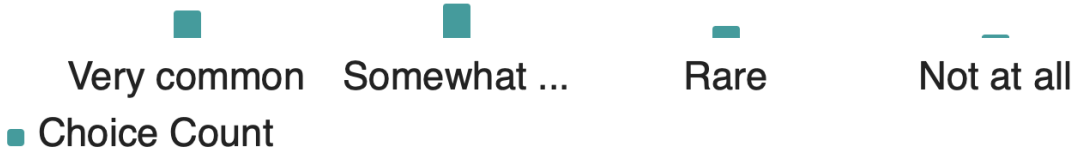
Response	Percentage (%)	Count (n)
Community leader/ mosque board	11%	9
Health professional	22%	19
General attendee	67%	57



Q7. Understanding of addiction and effects (N = 86)

Response	Percentage (%)	Count (n)
Excellent Understanding	33%	28
Moderate understanding	43%	37
Somewhat understanding	21%	18
I am not sure	3%	3

Q8 - Perceived Prevalence In your opinion, In your opinion how common is addiction (alcohol, drugs, gambling, pornography, etc.) within Muslim communities in the U.S.?



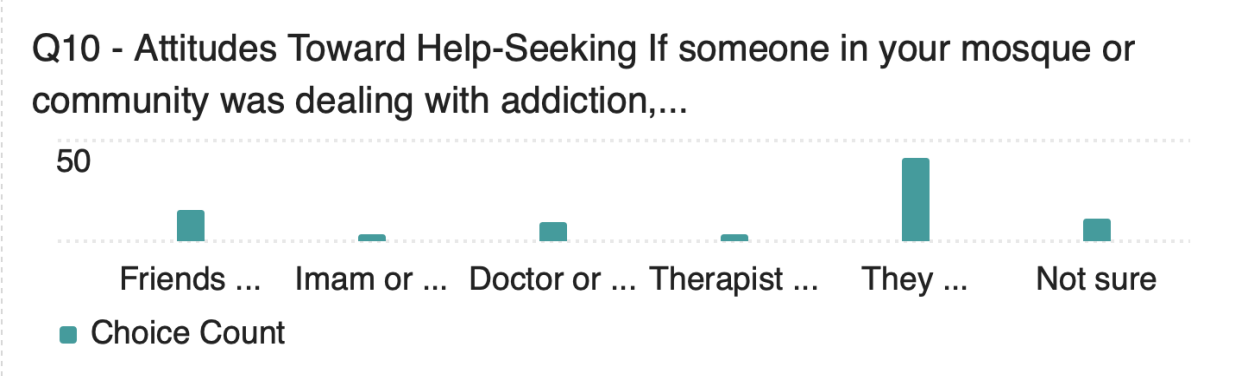
Q8. Perceived prevalence of addiction (N = 85)

Response	Percentage (%)	Count (n)
Very common	36%	31
Somewhat common	47%	40
Rare	15%	13
Not at all	2%	2

Q9 - Personal or Indirect Experience: Have you ever personally experienced, or known someone who has experienced, any of the following substances or experienced these behaviors? (Check all that apply — your responses are anonymous.)

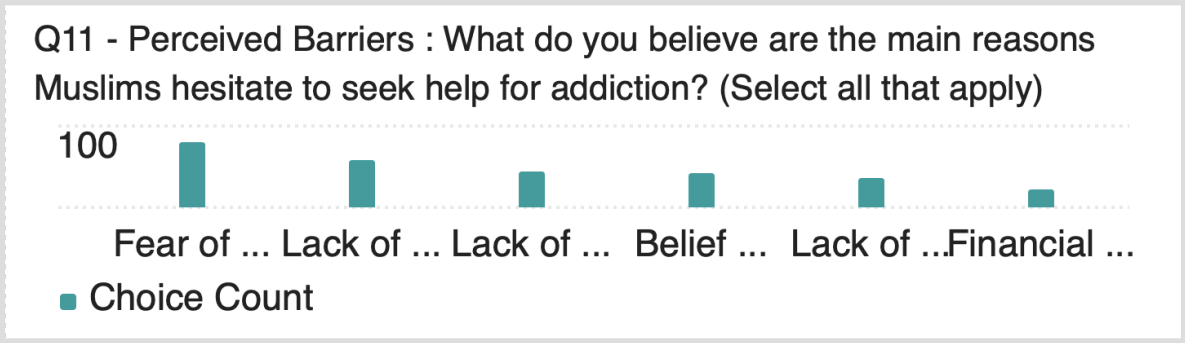
Q9 - Personal or Indirect Experience (N = 70)

Response	Percentage (%)	Count (n)
Alcohol	53%	37
Cigarettes or vaping products	89%	62
Gambling	27%	19
Marijuana or cannabis products	41%	29
Prescription pain medications (e.g., opioids) used more than prescribed	26%	18
Prescription stimulant medication (e.g., Adderall) used more than prescribed	23%	16
Sexual or Pornography	46%	32
Street drugs (e.g., cocaine, heroin, methamphetamine)	20%	14



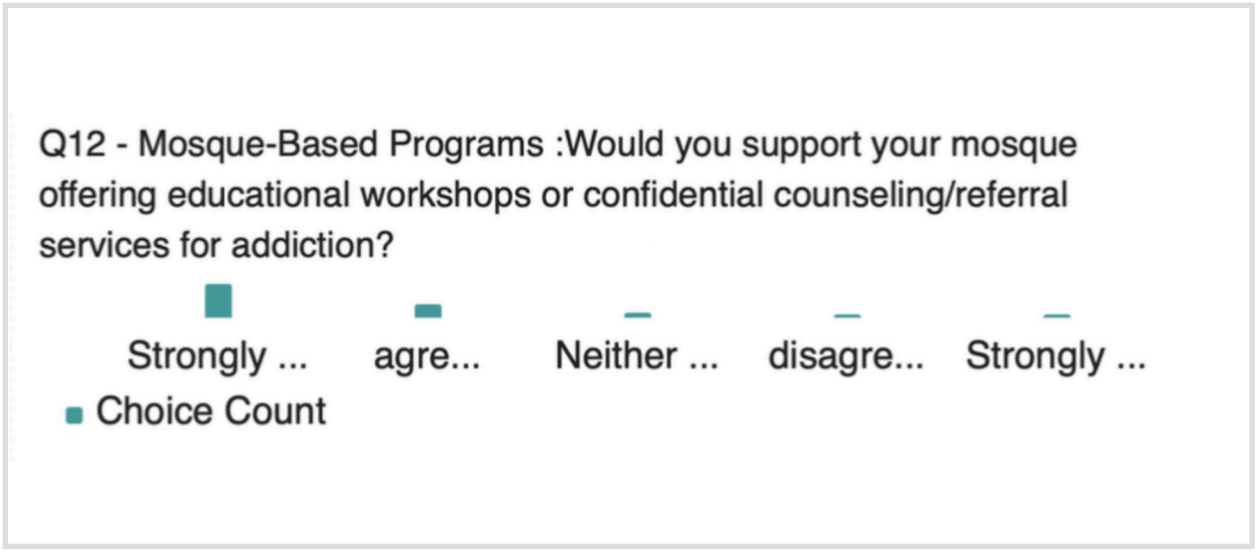
Q10. Attitudes Toward Help-Seeking (N = 86)

Response	Percentage (%)	Count (n)
Friends or family	19%	16
Imam or mosque leader	5%	4
Doctor or healthcare provider	12%	10
Therapist or counselor	5%	4
They would likely not seek help	48%	41
Not sure	13%	11



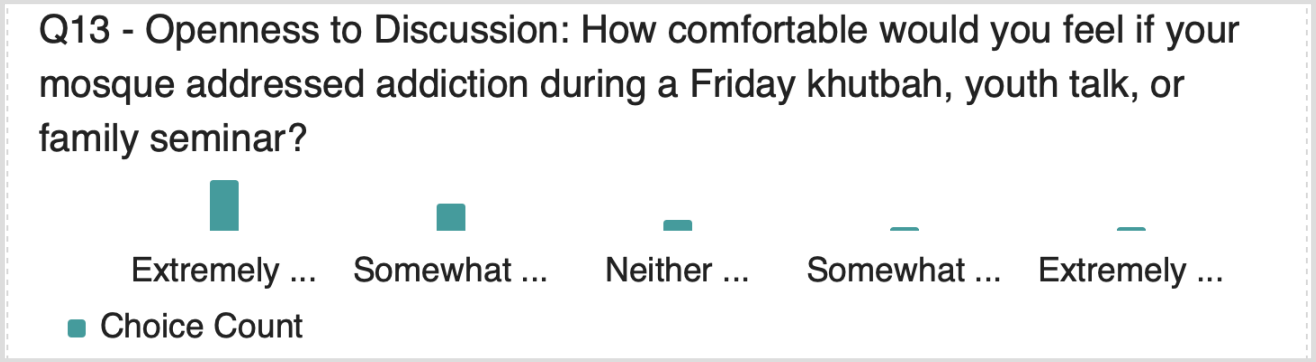
Q11. Perceived Barriers (N = 85)

Response	Percentage (%)	Count (n)
Fear of stigma or judgment	93%	79
Lack of confidentiality in community	67%	57
Lack of culturally sensitive care	52%	44
Belief addiction is sin/weakness	48%	41
Lack of awareness of treatment	41%	35
Financial/access barriers	26%	22



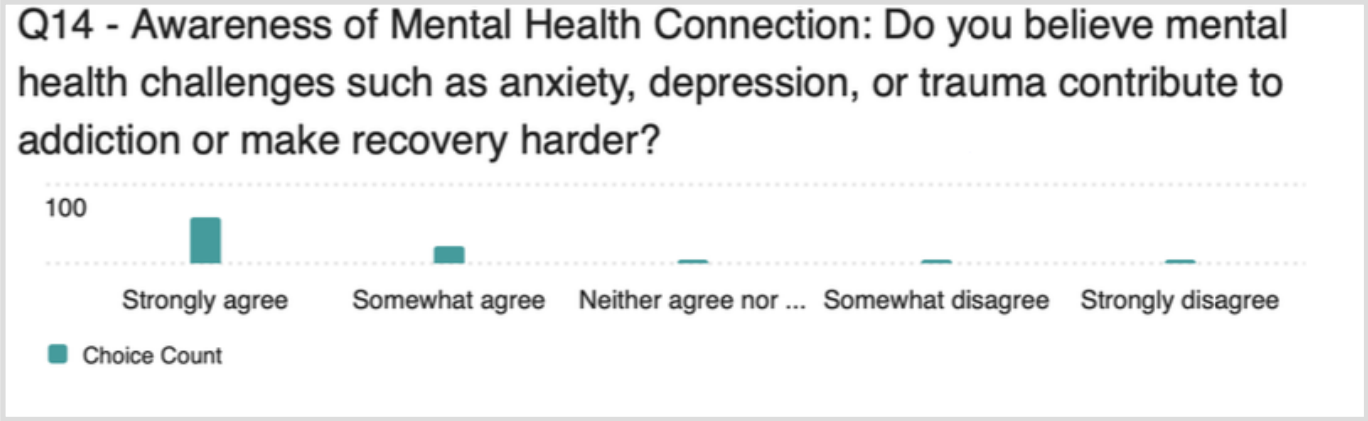
Q12. Mosque-Based Programs support (N = 84)

Response	Percentage (%)	Count (n)
Strongly agree	64%	54
Somewhat agree	25%	21
Neither agree nor disagree	10%	8
Somewhat disagree	1%	1



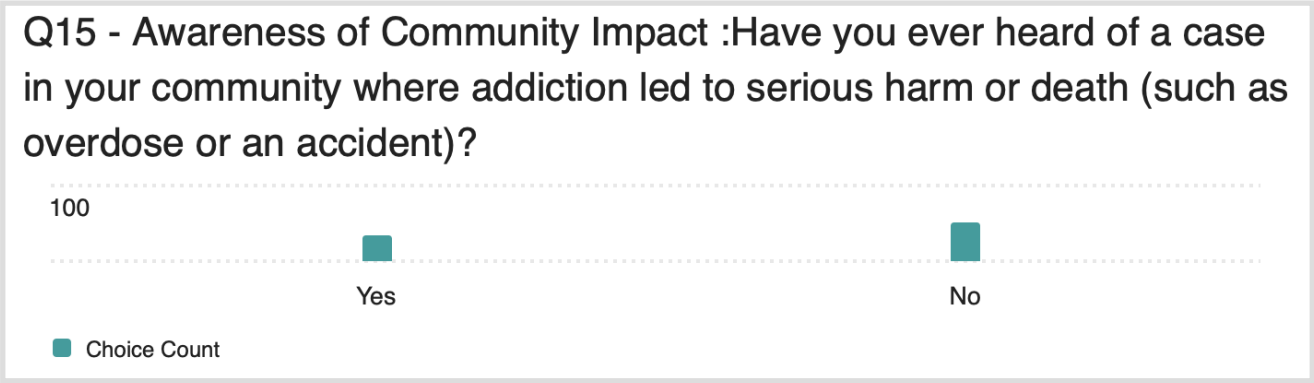
Q13. Openness to Discussion (N = 84)

Response	Percentage (%)	Count (n)
Extremely comfortable	56%	47
Somewhat comfortable	30%	25
Neither comfortable nor uncomfortable	13%	11
Somewhat uncomfortable	1%	1



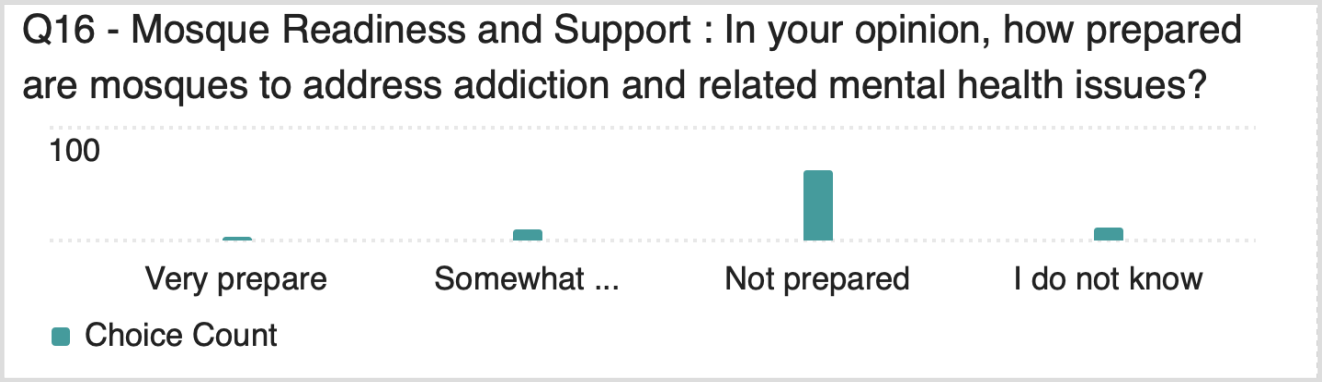
Q14. Mental health connection (N = 83)

Response	Percentage (%)	Count (n)
Strongly agree	69%	57
Somewhat agree	25%	21
Neither agree nor disagree	6%	5



Q15. Awareness of community impact (N = 85)

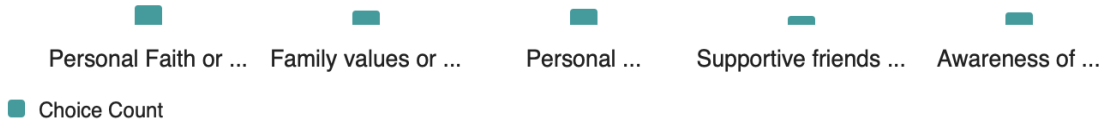
Response	Percentage (%)	Count (n)
Yes	39%	33
No	61%	52



Q16. Mosque readiness (N = 84)

Response	Percentage (%)	Count (n)
Very prepare	1%	1
Somewhat prepared	12%	10
Not prepared	74%	62
I do not know	13%	11

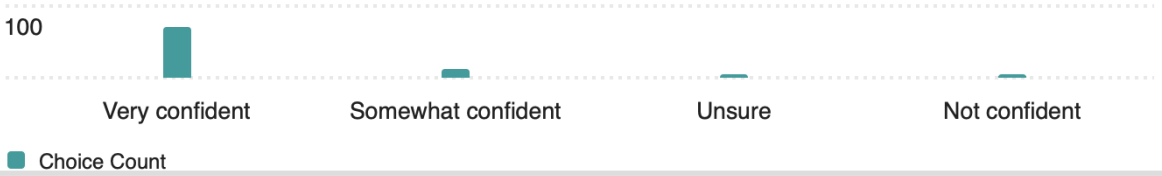
Q17 - Protective and Preventive Factors: If you have ever been exposed to situations involving drugs, alcohol, or high-risk behaviors, which of the following do you feel helped you avoid or resist them? (check all that apply)



Q17 - Protective and Preventive Factors (N = 80)

Response	Percentage (%)	Count (n)
Personal Faith or religious belief	85%	68
Family values or cultural expectations	63%	50
Personal boundaries or self discipline	66%	53
Supportive friends or Mentors	34%	27
Awareness of health risk	55%	44

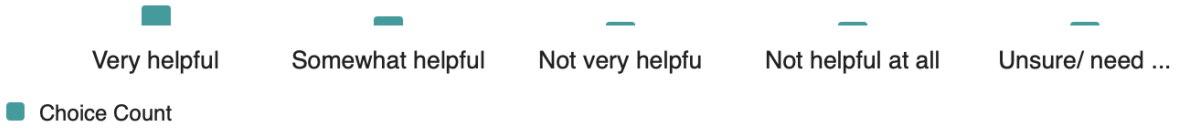
Q18 - Confidence in Resisting Peer Pressure: How confident do you feel in your ability to decline peer pressure if offered drugs, alcohol, or invited into high-risk behavior?



Q18 - Confidence in Resisting Peer Pressure (N = 84)

Response	Percentage (%)	Count (n)
Very confident	83%	70
Somewhat confident	13%	11
Unsure	4%	3

Q19 - Perceived Helpfulness of an Islamic Psychology Approach: In your opinion, how helpful can an Islamically integrated (faith-based) psychological approach be for Muslims struggling with substance use or behavioral addictions?



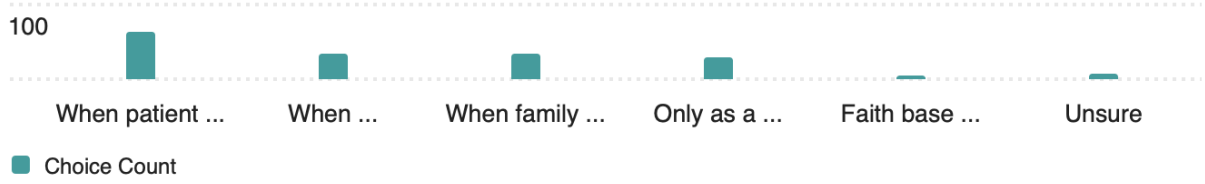
Q19 - Perceived Helpfulness of an Islamic Psychology Approach (N = 84)

Response	Percentage (%)	Count (n)
Very helpful	60%	50
Somewhat helpful	27%	23
Not very helpful	6%	5
Unsure/ need more information	7%	6

Q20 - Role of Healthcare Professionals in Faith-Based Referral (N = 84)

Response	Percentage (%)	Count (n)
Extremely important	49%	41
Very important	26%	22
Moderately important	20%	17
Slightly important	4%	3
Not at all important	1%	1

Q21 - Conditions for Faith-Based Referral: Under what circumstances should faith-based programs be included in a person's treatment plan? (Select all that apply)



Q21 - Conditions for Faith-Based Referral (N = 85)

Response	Percentage (%)	Count (n)
When patient request it	73%	62
When recommended by physician	40%	34
When family prefers it	40%	34
Only as a supplement to medical treatment	33%	28
Faith base program should not be included	2%	2
Unsure	7%	6

Appendix D

Interview Instrument

Interview Questions for Imam

1. Do you think addiction or substance use exists in Muslim communities?
2. When someone has an addiction problem, who do families usually go to for help first?
3. What role do imams or mosques have in helping people with addiction?
4. Why do some Muslims hesitate to seek professional help for addiction?
5. How can mosques and healthcare professionals work together to help people recover?
6. Should mosques provide education or programs about addiction and mental health? Why?
7. How prepared are our mosques to address mental health and or addiction?
8. Are you familiar with referrals to counseling or treatment programs through mosques?

Interview Questions for Healthcare Professional

1. Clinical Experience: Can you describe your experience treating American Muslim patients for substance-based or behavioral addictions?
2. Stigma & Disclosure: Do you find that Muslim patients are more or less likely to disclose behavioral addictions (like gambling) compared to substance-related issues?
3. Family Engagement: How do you navigate family dynamics when the family's understanding of addiction is rooted in religious prohibition rather than clinical pathology?
4. Cultural Sensitivity: What specific adjustments do you make to your treatment protocols (like 12-step programs) to make them more accessible for patients from a Muslim background?
5. Community Resources: Have you ever reached out to an Imam or a mosque to support a patient's rehabilitation, and if so, what was the outcome?
6. Barriers to Care: Aside from religion, what socioeconomic or systemic factors do you see hindering American Muslims from accessing addiction recovery services?

Interview Questions for Community Leader

1. Do you think addiction is an issue in the American-Muslim community? What are the barriers to seeking help?
2. Can you describe your experience working with individuals from the American Muslim community who struggle with substance use?
3. What are the most common "root causes" or stressors you see in Muslim patients seeking SUD treatment?
4. Did you make/try to make an institutional change within your work for your community?

5. What are the biggest barriers you faced?
6. How could mosques and healthcare professionals better collaborate to provide a "holistic" recovery model?
7. What specific training do you believe religious leaders need to become effective "first responders" for SUD?
8. If you could implement one change in how American mosques handle addiction, what would it be?

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