How do second generation Muslim men experience mental health problems within the context of their faith: An IPA study

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Abstract

As the second largest religion in the world, Islam has a following of over 1.8 billion people worldwide, with approximately 3 million Muslims living in the UK. Muslims and the Arab world have contributed to psychology and mental health as early as the period between the 7th and 13th centuries *(*Wael-Mohamed, 2012). Analysis of the existing research suggests Muslim men with psychological difficulties underutilise mental health services in the UK and research conducted with Muslim men is scarce when compared with studies focusing on Muslim women *(*Wael-Mohamed, 2012). With religious texts supporting and recognizing the importance of psychological awareness, and with the influence of Muslims within the psychological field, it is important to understand how followers of this faith view and experience psychological well-being and mental health issues. The participants were seven second generation Muslim men from different backgrounds, aged between 20 to 34, who had received no therapy. Semi structured interviews were analysed using interpretative phenomenological analysis.

Three superordinate themes were found: "Perceived stigma from community" – which explores the views of therapy and mental health from within the communities, "Mental health issues as seen from an Islamic perspective" – which looks into the influence of God, the devil and Jinn and the alternatives to therapy, "Intergenerational conflict and masculinity within Islam" – which discusses the masculine identity of Muslim men and the difficulties between second generation and first generation Muslim men.

The study suggests a community psychology approach be utilised for issues highlighted within the Muslim communities. Counselling psychologists could interact on a personal level and visit Muslim communities to increase awareness and engage in positive discussions around mental health. Furthermore, more training to bring awareness of cross cultural and religious demographics is suggested for counselling psychologists.

The translations of the meanings of the Quran are adapted from Sahih international, *the Quran: Arabic text with corresponding English meanings*, Jeddah, Abdul-Qasim Publishing House, 1997.

The Hadiths mentioned are from the hadiths collected after Prophet Mohammed's death which are just as important to Muslims as the Quran itself. The Hadiths mentioned are: Abu Dawood, Muslim, Ahmad and Bukhari.

All copies of the Quran and Hadiths remain unchanged and no two copies differ from each other, therefore any copy of any of these religious texts can be read to clarify any references.

Reflexive statement – part one

The reflexive statement identifies and elaborates ways in which the researcher may be influencing and interacting with the research through her experiences, views and beliefs. The reflexive statement has been split into two sections: the first section goes through reflections prior to the research taking place and the second part (following the discussion chapter) discusses the reflective points of the entire research process and how this has impacted the researcher. The subsequent reflective section will use the "I" frame of reference as it is based on the researcher's subjective beliefs and opinions.

Although there are over a billion followers of Islam, each individual expresses and practices their faith in a specific and unique way to other followers of the same faith. Therefore it can be said that there are differences in regards to beliefs and that interpretations of religious text can also vary from person to person. I will need to bear this in mind when reviewing my literature, interviewing participants and analysing the data. As I am a Muslim there are ways in which my beliefs and practices of my faith could be seen as being in accordance with the Quran, whereas other aspects of my interpretations and practices of beliefs may seem dissimilar to other Muslims; likewise, other Muslims' views and practices may seem uncommon to me. Therefore it is important that I remain mindful of this during the critical reviewing process of the literature, interviews and analysis stage as I would not want to project my own views and opinions on to the participants and distort the findings.

I would need to remain conscious of the fact that I have assumptions about what the research will conclude, which are that mental health, as it is viewed by westernised society today is incompatible with the Islamic faith, whereas my own belief is that they are indeed compatible. Therefore I need to remain aware of any readiness to negatively evaluate any literature that goes against my beliefs, any unconscious cues during the interviews and not analysing the data to reveal themes or conclusions that I believe to be true. I need to evaluate research in an inclusive way, not for it to solely confirm my assumptions, but for it to lead to a conclusive result in to what the current knowledge is on that topic (compatibility of Islam with Westernised mental health) and what needs/can be done to enrich and further our knowledge.

The purpose of engaging with this research is a personal search for me in trying to find an answer that will perhaps validate what I do. Growing up cross-culturally in both British and Asian environments has taught me that western societies are more accepting and recognising of psychological therapies than eastern cultures. It is often difficult to explain and validate my purpose as a trainee psychologist to family members and others from within the Muslim and Asian communities. There is an aspect of myself that would like to ask other Muslims if they acknowledge what psychology is and therefore recognise what it is that I do. I have experienced people questioning whether me being a counselling psychology trainee is compatible with my faith and even assume that I am going against my faith because of the profession that I have chosen. I feel as though others may believe that I am taking on a role that their imam or someone who is more religious should take. I am invested in showing that there can be psychological help from a contemporary, westernised perspective, within Islam and that the two are not opposed. Such a result would give me a sense of validation and would help alleviate any doubts that may sneak into my mind about whether I am doing the right thing - am I opposing my religion and

culture. I am hoping to find 'kindred spirits' in literature findings, authors whom can relate to me in being able to comprehend the relevance of psychology within the context of faith. I would also like to receive recognition from the participants and hope that they are able to somewhat validate my profession.

Being aware of my own views and how they could affect the study will also allow me to be more aware of the types of literature and past studies I include in relation to my topic and when analysing the data; I would not want to only discuss literature that supports my theories and views but rather grasping an understanding of the opposing arguments is critical in any form of research. Furthermore, my awareness will help to refrain from asking participants misleading questions – I will ensure this does not happen by trying to stick to the list of interview questions.

I have chosen to study this topic as it is of interest to me and my own need to find an answer to my questions. Growing up in an 'Islamic' environment meant that faith was a prominent aspect of my life from a young age and that the teachings of the Quran, love of God and prayers have always been close to my heart. Therefore, when I developed a passion for psychology, there was always the question of whether or not there were aspects of psychology that may be resistant to my faith and vice versa. There have been times when I have seen Muslims who are suffering from mental health issues, this has included my uncle. Being exposed to a mentally ill family member at a young age allowed me to see how this specific situation was dealt with from a religious perspective. There was a lack of acknowledgement of the depression being seen as a psychological issue and was rather discussed as being 'demonic' or 'possession' based. It was seen as a 'test from God' but not as a punishment by Him which followers of other faiths may see mental illness as or certainly other Muslims may even see it as such even though there are no corresponding religious texts which support the theory of illness being a punishment.

In the circumstance with my uncle, no medication was sought, no therapy was discussed and no medical or psychological experts were even considered. Rather, the idea of involving another person who was not part of the family or community would have been seen as seeking help from where it was perceived there was no help to be offered as God is seen as the ultimate Helper. However, Islam does not state that we should not ask for help from other human beings, so it has always made me wonder if whether Muslims understanding of their mental health issues derive from their faith or rather from their culture; there is often an overlap between religion and culture.

I would like to know how Muslims view their mental health issues and psychological well-being, whilst validating their religion as being an important and influential aspect of their lives. I would like to know how they perceive their mental illness and how this is viewed from a religious or cultural stance. I have pre-conceived views of what existing literature might reveal and what the participants may say, in terms of mental health, in that is it related to religion and a disassociation from God. I aim to not allow these assumptions affect the literature gathering process by including all relevant literature -selecting studies based on a non-judgemental basis and forming conclusions that are not misleading into giving answers that I want to see. Furthermore, it is important that I keep a reflective journal and review it regularly, to help recognise my biases and to review literature and analysis of the data objectively, in an attempt to minimise my preconceptions.

Chapter One

Critical Literature Review

This chapter introduces the topic area of Muslim men, Islam and mental health. The subsequent section summarises the review of current literature that focuses on religion and psychology, Muslim men's views on mental health problems and masculinity and Islam, followed by the rationale for the current study.

1.1 Introduction

Around 2.5 million followers of the Islamic faith reside in the UK, making up around 4.4% of the British population. This demographic is compromised of over 54 national backgrounds and over 70 spoken languages, but the majority of British Muslims are of Indian, Pakistani, Bangladeshi or Arab heritage (Fedele, 2013). According to the Muslim council of Britain, British Muslims are one of the most diverse Muslim communities on Earth (Pędziwiatr, 2007). The largest of these communities derive from South Asia, but there are also many Arab and African communities, as well as Turkish and south-east Asian. These cultures have many overlaps in traditions and values, such as Muslims from these backgrounds being traditionally raised in a collectivist culture, where the group or community's needs are deemed more important than an individual's needs. During the 1950's to the 1970's, the majority of immigrants arriving to England categorised themselves as Muslim; this suggests that many second and third generation Muslims experience a different set of customs and traditions from their first generation family members, thus suggesting a possible difference in how they view their worlds and their mental health (Pędziwiatr, 2007). Furthermore, research suggests possible overlaps of British south Asians perceiving a threat to their identity, similar constructs of masculinity and placing a great deal of importance on the role of honour for men (Gill, 2011).

As the second largest religion in the world with a following of 1.6 billion people, and arguably the most spoken about in the media in recent years, Islam has become a topic of conversation in the everyday lives of people (Wael-Mohamed, 2012). As therapeutic practitioners, it is important for us to be able to understand the viewpoints of this group of followers whilst bypassing the image of Muslims as based on media attention and news coverage (Philips, 1997). The belief in one God, following the examples set by prophets (especially prophet Mohammad who is believed to be the last prophet), reading the Quran (holy book), fasting, attending pilgrimage and giving to charity are the main principles of the religion (Ackerman, Ali, Dewey & Schlosser, 2009).

The Quran mentions three mechanisms that are directly related with mental health. They are: the *nafs* (psyche); *qalb* (heart) *and `aql* (mind) (Deuraseh, *et al*, 2005). The Nafs can sometimes refer to the spirit or soul but at other times can also refer to the power of lust, instincts and pleasure, much like that of Freud's 'Id' theory; a part of an individual which aims to satisfy his or her needs above all else. The Qalb is not referring to the heart

as an organ but rather to the sophisticated and cognitive aspect full of interrelated functions. Aql would refer to the conscious decisions and aspects of ourselves that we are aware of (Deuraseh, *et al*, 2005).

Therefore, from an Islamic perspective, it can be argued that focusing solely on the medical model and physiological treatments, is an active denial or neglect to the psyche, soul and mental health of an individual (Wael-Mohamed, 2012). This is contradictory to the research in the UK which shows that Muslim men are less likely than other demographics to seek therapeutic help. As this group are also understudied, there is little evidence in why there is a discrepancy between the Islamic teachings that encourage the importance of the psychological state and Muslim men in accessing help or acknowledging their mental health problems. Could this be from their understandings of masculinity, their subjective interpretation of their faith or other possible factors?

As Muslim men are underrepresented in the UK and in the research literature of psychological therapies (Ackerman, Ali, Dewey & Schlosser, 2009) and their needs remain unexplored. This review will thus investigate how Muslim men experience their mental health problems and how this might possibly be influenced by their faith. It will also explore the topics of masculinity and stigma associated with seeking therapeutic help whilst encouraging further research on religion and psychology.

1.2 Intergenerational differences, honour and acculturation

A study conducted in America by Haydon, Miller and Yang, M, (2013) found that intergenerational and familial conflict emerged as a result of cultural dissonance between the first and second Asian-American generations. Arif, Couture-Carron, Maticka-Tyndale, and Zaidi (2014) had similar findings in which the second generation are caught between two cultures in which they must navigate and change their demeanour and behaviours based on the notion of wanting to belong both inside and outside their homes and can lead to clashes with first and second generation South Asians over matters such as dating and marriage. Hopkins (2006) carried out an interview with 22 Muslim men who discussed that there was some indication of tensions between the young men and their fathers; it was also reported that the participants intended to try to construct an alternative masculinity to that of their fathers and grandfathers thus suggesting that they are aware of the generational differences and are perhaps wanting to deviate from the traditional roles that the first generation Muslim men adopted; lending to the idea that participants started to form identities of their own accord.

Jaspal et al (2012) discuss how first generation British south Asians perceive the continuity of their ethnic identity to be threatened by the white British majority. First generation south Asians tend to use singular ethnic categories (Pakistani, Indian, Bangladeshi) to define their ethnicity whereas second generation South Asians tend to reject singular categories and prefer adding the word “British” alongside Pakistani, Indian or Bangladeshi. It is suggested by Jaspal et al (2012) that these differences in identities could cause possible interpersonal conflict between the first and second generations to protect and enhance distinct motivational principles associated with their own identities. There has been limited amounts of research focusing on how these identities are actually managed and reconciled by individuals themselves. Studying such dynamics is important as these identificatory patterns are likely to have vast implications for identity principles. By

identifying themselves with dual identities, second generation British South Asians perhaps acquire a sense of ethnic distinctiveness from first generation British South Asians who may oppose their dual ethnic identities; it is important to conduct more research into which coping strategies the second generation populations adopt when their identities are threatened by the first generation.

Although research and literature suggest that family honour in south Asian as well as Muslim families is more directly linked to a woman's behaviour, Gill (2011) notes that in honour based societies "the man is the defender of his and his family's honour: it is his duty to defend it against any behaviour that might be seen as shameful or humiliating by his community" (p. 246). Interestingly, Gill (2011) writes female honour is static; it cannot be increased nor regained, and when it is lost, this is forever. In contrast, male honour is dynamic and in a constant state of flux; it can be maintained and increased through active participation and competition in community life. Arif et al (2014) discuss the collectivistic nature of many South Asian cultures, where family members are expected to consider the needs, position, and honour of their family over their own needs or desires. If the man is viewed as the defender of his family, along with the expectation that he also participate in community and place the desires of others above his own, how does this impede or impact on his own mental health, at the cost of honor?

It is important to note the role that acculturation plays in ethnic and religious minority communities in a bid to understand nuanced dynamics. Acculturation is the phenomena that results when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original cultural patterns of either or both groups. This process includes psychological, sociocultural, and economic acculturation. Attachment to people and places contributes to a stable place identity that is also threatened by migration and displacement (Bhui, Stansfeld, Head, Haines, Hillier, Taylor and Booy, 2005). Goforth, Oka, Leong and Denis (2014) carried out a study in which they wanted to explore how acculturation, acculturative stress, and religiosity were associated with psychological adjustment among Muslim Arab Americans. 128 Arab Americans participated; age, gender, religiosity, and length of time in the U.S. were found to significantly predict heritage cultural orientation but not mainstream cultural orientation. Moreover, acculturation and acculturative stress significantly predicted psychological problems.

Furthermore, Farver, Bhadha, and Narang (2002) carried out a study to understand how Asian Indian immigrant families adjust to U.S. culture by examining how acculturation styles may be associated with their children's psychological functioning, as measured by self-esteem and academic performance. 85 U.S.-born Asian Indian adolescents (45 girls; 40 boys) and one of their immigrant parents completed questionnaires about family demography, self-identification, acculturation, and religiosity. Adolescents also completed a self-perception profile. Results showed parents and adolescents had similar styles of acculturation. However, adolescents were more likely to self-identify as 'Indian-American' than were their parents. Adolescents who had an integrated acculturation style had better grades at school and higher scores on the self-perception profile than did adolescents who were separated or marginalized. The findings lend tentative support for an integrated style of acculturation in promoting positive outcomes for second generation Asian Indians. Integrated individuals experienced less 'acculturative stress' and anxiety, according to Farver et al (2002), and manifested fewer

psychological problems, than those who were marginalized, separated, or assimilated. Overall, marginalized individuals suffered the most psychological distress, including problems with self-identification and cultural alienation which adversely affected their self-esteem. It would therefore be important to conduct research with second generational men from south Asian and Muslim backgrounds to explore if such acculturational difficulties and differences between them and the first generation in terms of acculturation affects their mental health, and to what extent.

1.3 Religion and psychology:

Previous research suggests quite a sceptical attitude towards the uncertainty of religion and psychology according to Cowie and Hayes (2005). However more recent research conducted within the last decade or so, shows that the focus on these areas has become more widespread, allowing these topics to shed light upon the important links between religion and psychology (Utz, 2011). With notable exceptions, there are many psychologists who would describe themselves as materialists that believe primarily on the focus of our bodies and mental worlds (Brown, Elkonin, and Naicker, 2013). According to Brown *et al* (2013) psychologists are less likely to be religious than are members of the general population. A study from the USA found that psychologists were less likely to pray, three times more likely to describe religion as unimportant in their lives and five times more likely to deny the belief in God than the general population (Utz, 2011). Of course, this does not imply that psychologists do not incorporate religion into therapy because they themselves do not identify with a religion. However, this raises the question of whether or not Muslims are able to engage with therapy if there is little or no mention of it during the sessions.

In contrast to the above, counselling psychology has begun to take into account the significance of spiritual and religious experience of clients. Ackerman, Ali, Dewey & Schlosser (2009) argue that psychology and religion have constructive implications for the therapeutic progress. The influence of religion on client-centred therapy is evident in the emphasis of individual personal growth and the use of intuition and feelings as a guide instead of a doctrine. The argument is not that therapists need to be interested in the religion as such, but rather that they need to acknowledge and use the therapeutic experience as a bridge between psychology, religion and spirituality for their client (Ackerman *et al* 2009).

Therapists need to be conscious of any possible resistance within them in dismissing the role that religion can play in the course of therapy. West (2008) states that this could especially be unhelpful to clients who may attend the mosque, church or synagogue. For such groups of people, the dismissal of their religious views and experiences can serve as a hindrance to the therapeutic alliance. With Muslims being less likely to engage in therapy and openly seek psychological support, the incorporation of religion and spirituality into therapy are vital in engaging and developing a rapport with this population (Argyle, 2002).

In a study by Shafi (2007) where she surveyed four Asian, Muslim, American women, she found that these women were not particularly concerned about the ethnicity or religious views of their counsellor but only considered cultural awareness from their therapists as being a vital quality. The participants reported feeling

'understood' and 'able to confide' from therapists who they reported as being culturally aware and active in discussing religion and culture. Therefore, when therapists are less culturally or religiously aware or likely to incorporate religion and culture into therapy, the opposite effects are more likely to occur; leaving the client feeling unheard and unable to confide with the therapist (Shafi, 2007).

Brown *et al* (2013) used a qualitative descriptive method to collect data from psychologists regarding their willingness to discuss religion and spirituality within the therapy room. The results showed that although most of the professionals seemed inclined towards the incorporation of religion into the therapy room, they still discussed potential barriers which they felt religion bought to the therapist-client relationship. "Lack of knowledge, understanding and training" and "Having clashing morals and values with the client" are two major themes discovered by Brown *et al* (2013) when psychologists discussed potential barriers to use religion and spirituality in therapy.

In contrast to the findings by Shafi (2007), where participants did not necessarily regard the psychologists' religion as being significant, the participants in the study by Brown *et al* (2013) discussed that "Clients wants to be with a therapist of their own religion". It is unknown from this latter research if these views are the psychologists' own or if they are directly influenced by clients they have worked with. Nevertheless, the reluctance of incorporating religion into the therapy room could be viewed by clients, in my opinion, as a lack of cultural and religious awareness which could lead to alienation and disregard towards client's feelings, values and beliefs. If we as professionals want Muslims and individuals from other religious or minority groups to access psychological help, then the willingness to discuss their faith and other cultural issues should be a key component and topic of discussion within the therapy room. Perhaps this could be aided by appropriate training to reflect the feelings of inadequacy discussed by the psychologists in Brown *et al* (2013)'s study.

Tarabi, Loulopoulou and Henton (2018) state that with the atmosphere of fear and controversy that surrounds Muslims at this time, it is hardly surprising that they feel unable to voice their fears and concerns openly. Added to this is the fact that Muslims already underutilize mental health services (Bennett, *et al,* 2000). Although there are studies reflecting the therapists' willingness to incorporate religion and spirituality into the therapy room with Muslims and followers of other faiths, there is a lack of research, with the exception of Tarabi *et al* (2018) and Shafi (2007), where researchers are directly conversing with Muslim participants in a bid to understand what they require from their psychologist. Such identifiable qualities could be an insight into the reluctance of Muslims seeking psychological help but also the possible steps that could be taken to adapt therapy and how it could be available to them in an inclusive manner reflecting their needs (Wael-Mohamed, 2012).

Ackerman, Ali, Dewey, and Schlosser (2009) discuss the lack of research on Muslim and Jewish clients. They state that in the USA, of all doctoral training programs, only 8% of the courses covered Jews as a distinct cultural group and only 2% of these courses presented Muslims as a distinct ethnic group. The majority of training discussed Christianity when religion was explored as this was deemed a 'universal' religion. Such an underrepresentation of research and training at doctoral level could have an impact upon the reluctance of being able to incorporate religion with these groups of people; therefore, therapists need to be trained in working with these individuals if we want to follow the values of counselling psychology (Wael-Mohamed, 2012). Even though research is now rich in relation to studying the role of religion and psychology, there are not many

studies that look at the subjective views of individuals who practice certain faiths in how their interpretation of their religious beliefs influences their relationship and views on mental health (Ackerman *et al,* 2009).

1.4 Islamic therapeutic interventions:

With the acknowledgment of the vital role that religion and spirituality play in the psychotherapeutic process and that it can be a useful tool in being a part of the solution to psychological problems (Bergin & Richards, 2005), I will be discussing some therapeutic approaches that have been adapted for Muslim clients.

More could be understood about Muslims according to Fedele (2013) if we asked what their relationship is like with God. Therapists are open to discuss client's relationships with other key figures in their lives such as parents and their partners, but may hesitate to discuss the client's relationship with God. Rather than focusing on materialistic goals and attaining social status, perhaps more spiritual goals should be sought. Such as achieving a spiritual domain or seeking a closer relationship with God. Bergin *et al* (2005) believe that theistic holism should be adapted into therapy with Muslim clients, the belief that human beings are holistic, spiritual beings, made of an eternal soul or spirit; humans should not just be reduced to their biology, relationships and mind.

Salma (2006) proposes using the 'Islamic model of self' with both Muslim and non-Muslim clients. This model aims to work particularly better with Asian and Arab clients as it localises distress in the heart as opposed to the head and mind. Many non-western cultures express their distress in relation to their heart as reflected by the languages used in a metaphorical manner, such cultural awareness is crucial when working with any client from such backgrounds, especially asylum seekers and refugees. An Islamic perspective of understanding self includes insight into the spiritual aspect of the self and could be a potential therapeutic approach when working with Muslim clients according to Salma (2006).

Qulsoom (2001) discusses a therapeutic approach with Muslim clients in which the purpose of the therapy is to explore the purpose of life and life events and develop a greater awareness of human ability. Identifying patterns of behaviour depending on the client's personality type and making goals are some of the techniques mentioned. However, none of these methods seem as though they are specific to counselling Muslim clients only, rather these core methods can be and are applied across therapy with most clients. She proceeds to discuss that goals should be centered on reaching a closer proximity with God. However, it is inaccurate or indeed unfeasible to believe that this would be the goal of every Muslim in psychological distress; such assumptions could lead to Muslim clients feeling guilty about their relationship with God and feeling as though their mental health issues are a result of their own religious neglect (Ackerman *et al,* 2009).

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Through the use of case studies, past literature and based on their experiences with Muslim women in counselling, Cook-Masaud and Wiggins (2011) have developed strategies for counselling female Muslim clients. They believe the fundamental principle of such an approach with this population is to build a trusting client-therapist relationship through the development of rapport building. They also highlight the significance of

knowing basic Islamic teachings and beliefs whilst at the same time knowing that these are not a reflection of the client's subjective meaning of their faith. Becoming culturally responsive towards the client was also a method of counselling Muslim women along with empowerment, discussing ideas of interdependency and external locus of control. Cook-Masaud *et al* (2011) also discussed the implementation of providing education, addressing gender roles, addressing spiritual issues and reviewing sacred texts as methods of counseling whilst honoring the client's practices and religious beliefs. Such research is paramount in being able to develop techniques in which Muslims feel understood. It would be interesting to see how these authors would have approached Muslim men in counselling and how this would differ from the techniques used with Muslim women. It would also have been beneficial to have input from the clients on how useful they find these particular therapeutic methods and interventions to be during therapy and if there is anything that they feel they would add to improve and progress the therapeutic journey (Cook-Masaud *et al* 2011).

There are some aspects of therapy that may contradict the teachings of Islam such as unconditional positive regard which is derived from the person centered approach. Islamically, when another Muslim is committing a sin, it should not be ignored or condoned but rather they should be supported in rectifying and modifying their behaviour if possible. However, such judgments and any form of advice giving, have no place in any current methods implemented by counselling psychologists (Pargament, 1997).

However, in a study by Azhar, Dharap and Varma (1994), religious psychotherapy in the treatment of anxiety, depression and bereavement with Muslim clients, produced positive results. In the majority of such studies, the religious psychotherapy groups responded much quicker than the groups that were receiving standard treatment. The type of Islamic psychotherapy used was aiming to identify unhelpful thoughts and then modifying them with beliefs from the Quran and Hadiths – similar to the patterns of replacing negative automatic thoughts in cognitive behavioural therapy. The participants were also on occasion asked to repent if they bought up feelings of guilt and/or a sinful conscience. In addition to incorporating these dynamics into therapy with Muslim clients, Hamdan (2008) believes further approaches that could be incorporated would be: helping the clients to focus on the hereafter, focus on the blessing from God, trusting and relying on God and recalling the benefits of distress and afflictions from an Islamic perspective.

Such approaches are trying to include the Quran's context of the faith into the therapy, but at the same time there is little to no evidence supporting the effectiveness of such a collaborative therapeutic approach. Furthermore, as every Muslim interprets their faith subjectively, it is therefore doubtful that such therapy could be generalised across psychotherapy for all Muslim clients. Also, the suggestion for recalling the benefits of distress and affliction with Muslims during their therapy may help them accept life circumstance that cannot be changed but at the same time might be a passive approach that could lead to the client not actively engaging in trying to work towards resolving problems that can be resolved (Al-Hashimi, 2007).

In addition to the above, Muslim clients may also be asked to pray five times a day, read the Quran and remember God frequently. Such approaches could promote relaxation and a general sense of wellbeing for the clients. Even though many studies have tried to incorporate religion into therapy for Muslim clients, there is no research in which Muslims are directly asked what they understand and perceive psychological wellbeing and mental health to be. Studies implementing religion into therapy do so based on the teachings of the Quran and

Hadith (Qulsoom, 2001). Although all Muslims read the same interpretation of the Quran, be it in any language, and no two copies of the Quran are different to each other, all human beings interpret the words from their own perspective. Therefore, not all Muslims may have the same thoughts about mental health and what it means to them. As a result of this, I would argue that all therapies that incorporate religion, should do so by trying to initially understand that particular religious population as well as familiarising themselves with religious texts. This is the only way that the therapies will be inclusive of the ideas and views of the Muslims in regards to mental health in the first place and how they think mental health fits into their faith based on their interpretation and understanding of the religious texts (Qulsoom, 2001).

1.5 Masculinity, mental health and Islam

A reason to focus on men's mental health is because according to the literature men underutilize health services (Tarabi *et al* 2018). According to (Addis & Mahalik, 2003), men seek less support than women for every mental and physical health problem for which help-seeking has been studied. There has been a developing amount of theoretical literature exploring how interpretations of masculinity significantly impact upon mental health and wellbeing. According to Barclay, Harland and McNamee (2006), understanding how masculinity affects male behaviour and development is an important aspect of trying to comprehend the reasons why men hesitate to openly discuss mental health problems when compared with women. Previously, men's mental health was not a focus of substantial research in its own right. Whilst it is true that many men have participated in research studies, men's gendered experience itself has rarely been the primary consideration in theory or method (Utz, 2011).

Many men can feel confused or uncertain about what their concept of masculinity is as the issues surrounding it can be contradictory and complex (Barclay *et al,* 2006). Acknowledging masculinity related contradictions is important when trying to understand the pressures men face in regards to their mental health and wellbeing. Masculinity concepts can be comprehended as being beliefs about what it means to be a man and what both acceptable and unacceptable behaviors are for men (Fedele, 2013). There has been an emphasis for future research to focus on understanding the ways in which men express and experience mental health problems as this will also benefit women and children and men themselves; in addition to this, researchers have emphasized the diversity of men's experiences whilst taking into consideration other social categories such as ethnicity, social class and religion, which could all impact the ways in which masculinity is viewed (Utz, 2011).

The understanding from previous research is that masculinity is not an objectively viewed concept; theorists highlight the ways in which religion, race, ethnicity and social classes can all have an influence on the construct of masculinity; Addis and Cohane (2005) highlight this point by comparing the differences in the views of masculinity between white suburban masculinities with Latino masculinities. There is little research on the concept of masculinity with Muslim men, or indeed the possible influence that the faith, Islam, has on their construct of masculinity. Bowl (2007) reports that Muslim and South Asian communities under-utilise

mental health services, therefore there is a dire need to allow Muslim men to be heard on why they are not engaging in help-seeking behaviours. According to Addis and Mahalik (2003), more traditional ideologies of masculinity expect men to solve problems themselves, view mental health problems as being a sign of weakness, whilst other masculinity constructs such as the discrimination faced by other men and the uneven distribution of power amongst men could all contribute towards not seeking therapeutic help. By engaging Muslim men in a bid to understand their potential views of masculinity and recognising which factors influence their views and behaviours, we can assist with which possible route could be most beneficial with helping Muslim men (Qulsoom, 2001).

Consistent findings are showing that as a group, men of different nationalities, religions, ages and ethnic backgrounds are seeking less help than women do (Levant 2011). Further to this, Addis *et al* (2003) state that there is less help seeking through psychiatric services, psychotherapy and counselling services by men, when compared to women. Previous research such as that by Levant (2011) looks at the differences between men and women when seeking help for mental health problems. The study also explores social and biological processes that might contribute towards the observed differences between men and women. However, previous research has left it unclear as to why men specifically are less engaging with services; there is the possibility that these behaviours may stem from men's greater independence and self-reliance when compared with women, or an inability to recognise problems (Levant, 2011).

Therefore, an alternative approach is suggested to the gender-difference approach in an attempt to understand men's help seeking behaviour specifically as a product of masculine gender roles based on role socialisation. Role socialisation assumes that men and women learn behaviours and views from cultural values and ideologies related to what it means to be a man or woman (Addis *et al* 2003). Previous research such as that by Englar-Carlson and Kiselica (2010) suggest that masculinity surrounding the notion that admitting a need for help or recognising the difficulties at all are in contradictory to the messages men receive about the importance of pretending to be strong and displaying hardly any emotion-related problems.

When exploring the concept of masculinity and mental health within Islam, research is scarce. Research looking at men on a broader level shows that views around masculinity influence men's understanding of mental health (Barclay *et al,* 2006). Therefore, Muslim men potentially underutilizing services and their views and experiences of mental health problems could possibly stem from their interpretation of their faith and also from their masculine identity that could also be possibly influenced by their cultural and religious beliefs Addis *et al* (2003).

Farooq and Parker (2009) state that the plurality of British Muslim masculinities is largely ignored, and Muslim masculinities are assumed to be associated with ideas that stem from a male adherence to Islamic principles over-simplistically associated with Islamic fundamentalism. With these assumptions in mind, there is a need to better understand the multiplicity of Asian masculinities among young British Muslim men, and to more readily recognize religion as a category of influence for identity construction as this can then have a direct influence on the acceptance or denial of mental health problems as well as the ability or inability to recognise and seek therapeutic help (Farooq *et al,* 2009).

Farooq *et al* (2009) confirm findings from previous research where Muslim male participants spoke about how they believe the media portrays Muslim men in a derogatory manner. Despite these portrayals causing Muslim men to be misrepresented, they did not believe there was a crisis between Western societies and Islam. In fact, most of the participants instead argued that the actual problem they faced was battling an inner conflict between staying within the boundaries of Islamic teachings whilst trying to avoid the temptations from their cultures alongside the distractions of Western life. It then leaves one to ponder about whether or not this uncertain dynamic between both Islam and Western culture affects Muslim men's views on psychology and how they engage with and view mental health problems in general (Farooq *et al*, 2009).

It seemed as though the participants from Farooq *et al* (2009)'s study viewed the leniency towards western traditions as being negligent of their relationship with God and their faith. Many of the men in the study turned to the Quran and Hadith to seek guidance on what it means to be a man and therefore establish a concept of masculinity. All the Muslim men saw the prophet Muhammed as a representative of character for all Muslims. They described him as being calm, compassionate and abhorrent towards anger and violence. Other participants discussed how their understanding of the Quran is that they should turn to other Muslim men for help when they are having problems of any kind; the Muslim men discussed seeking spiritual and moral support from God and the prophet and social support from other Muslims. Thus implying that perhaps the same resources are utilized when the men also face mental health problems. From studies like that of Farooq *et al* (2009), it highlights how for some, religion can be a cohesive influence in the formation of identities and the construction of the self, including masculinity.

Fedele (2013) viewed religion as being the centre of the construction of gender identity and what it means to be a Muslim man. Therefore, the teachings from the Quran and Hadith could be a necessary tool for these men when they are seeking to understand masculinity through how their roles, behaviours and mannerisms are carried out. Since everyone's relationship with God is unique and the Quran and Hadith and religious texts are open for interpretation with the understanding of specific ideas being subjective, this could arguably allow for greater flexibility in the Islamic concept of masculinity. Thusly, Islamic masculinity would theoretically differ between Muslim men even though they follow the same teachings. There could be overlaps between the masculinity concept as ultimately the subjective interpretation is based on the same sacred texts which define the same strict boundaries and guidelines (Barclay *et al*, 2006). Since Muslim men are less likely than non-Muslim men to seek therapeutic help, this begs the question of whether the way in which Muslims men form their concept of self and masculinity derives from their faith and how their interpretation of their religion influences their views on mental health.

According to Samuel (2011), there has been little discussion of the development of Muslim masculinity. Samuel (2011) suggests that the Quran places a large responsibility on men to be responsible guardians of women (mothers, sisters, wives and daughters). While there has been a vast interest in research in relation to the burqa, the hijab and Muslim women dressing modestly, there has been almost no attention to the Muslim men and practices often associated with the same movements. While religion has been seen as an important factor in

forming the construction of femininity, and despite the stereotypical view that Islam contributes towards oppressive gender relations, there has been a scarce amount of attention to religion in the context of the construction of masculinity and the impact that this could possibly have on the individual's relationship with mental health (Addis *et al,* 2003).

1.6 Stigma of psychological distress amongst Muslim men

Ciftci (2012) states that even when Muslims have positive attitudes towards psychology within Islam, social stigma still remains increasingly strong. This could be due to the concerns that individuals have about family social standing, with many researchers reporting that the disclosure of mental illness is considered "shameful" (Aloud & Rathur, 2009). In a study by Alem, Fekadu, Jacobsson, Kebede, Kullgren, Negash and Shibre, (2001), 75% of Muslim Ethiopian families reported experiencing stigma due to a relative with mental illness; with substantial minorities (36.5%) reporting that other community members would be unwilling to marry into their family because of the mental illness. Ciftci (2012) suggests that Muslim women may avoid sharing their personal distress and may be reluctant to seek help from counsellors due to fear of negative consequences with respect to marital prospects or their current marriages. In a study by Abu-Ras, (2003), of the 67 immigrant women who reported receiving domestic abuse, 70% of them felt feelings of shame and 62% felt embarrassment for seeking formal mental health services. Furthermore, in a study by Khan (2006) 459 Muslims in the USA revealed similar gender patterns in stigma and help-seeking. The results from this study showed that from the 459 participants, 15.7% of the participants reported a need for counselling while only 11.1% reported ever seeking mental health services. These results also showed that Muslim women expressed higher levels of need for mental health services than Muslim men; men also reported more negative attitudes towards help-seeking. In contrast to this, Hatthakit, Suttharangsee and Vanaleesin, (2007) found that participants and family members of participants in the Thai Muslims community, rejected the idea that schizophrenia had stigma since the illness was Allah's (God) will.

Aloud and Rathur (2009) investigated the attitudes of Arab Muslims toward seeking and using psychological services within the USA. The results from 360 questionnaires showed that Arab Muslims' attitudes toward seeking formal mental health services are affected by cultural and traditional beliefs about mental health problems, knowledge and familiarity with these services, the perceived levels of social stigma and the use of informal indigenous resources. Stigma associated with mental health therefore possibly plays a vital role in whether or not a Muslim will seek psychological help. Perhaps these stigmas are associated around community values as well as cultural norms but must be recognised as playing a role in people's chances of seeking counselling (Aloud *et al,* 2009). Further studies could be conducted in which a qualitative approach is used to establish the influence and process of such stigmas within these communities and what can be done to tackle such obstacles in a bid to develop inclusive mental health services; such studies are under examined, especially in the UK and could prove beneficial since in an attempt to avoid bringing shame to the family, many Muslims are reluctant to share details of their personal life with people other than trusted close relations (Qulsoom, 2001).

Despite the importance and complexity of the topic of mental health and psychological wellbeing, the Arab world still shows a lack of awareness regarding mental health problems; mental health services and professionals are scarce. Alean, (2005) conducted a review in which it was found that mental health patients in Arab countries expressed their psychological problems in terms of physical symptoms; this allowed them to avoid the stigma associated with mental health. Their thoughts towards mental health services were negative, which was reflected by the under usage of these services. Instead of utilising mental health services, the review showed that reliance upon God and help of religious leaders as a means of coping were prevalent themes within the Arab world (Alean, 2005). Such studies are yet to be conducted in the UK, where Muslims are asked how they view psychological problems; it would be interesting to see if Muslims also described their illness in terms of physiological problems to avoid the stigma attached to mental illness. Of course, studies in Arab countries enduring political unrest where there are bound to be higher rates of mental health problems, are a cause for concern if the residents are unwilling to seek psychological help because of stigma and perceived religious influence (Farooq *et al*, 2009).

Ackerman, *et al* (2009) reports that in the USA, of the religiously motivated hate crimes committed in 2005, 150 (10.7%) were anti-Islamic. Members of this group may be subjected to negative attitudes and hostility which may lead to feelings of psychological distress. Therefore, stigma from within the community may not be the only type of stigma that Muslim men face; they may feel as though society as a whole, and potentially even their therapist, may have pre—conceived ideas about them and their faith which may fuel their reluctance to seek psychological help. Ackerman, *et al* (2009) found that Muslims wanted a counsellor who has a good understanding of Islam in order to battle these assumptions and stigmatised ideas of what Muslims and Islam are about. Counsellors need to address Muslim clients' attitudes about seeking counselling, including the perceived stigma associated with issues related to mental health. Being aware of stereotypes is a good way of building rapport with Muslim men who may be feeling stigmatised.

Bossley and Crosby (2012) conducted a study in which 235 college students participated. The purpose of the study was to examine preferences for religious help-seeking as well as several variables that have previously been associated with help seeking attitudes such as gender, age and ethnicity. As a result of stigma and in a bid to eradicate any association with mental health problems, individuals may seek the help of a religious leader (imam, priest etc) when facing psychological distress rather than a professional. The results from Bossley e*t al* (2012)'s study showed that a key predictor of preferences for religious help-seeking (for a psychological problem) is the level of religiosity that the participant reported. Those higher in religiosity may be more inclined to view religious help-seeking as a positive and feasible alternative to psychological services. Therefore, a possible link can be seen between these two variables, however, it was not stated what is it about this higher level of religiosity that makes one more likely to seek the guidance of a religious leader rather than a mental health professional. It could also be argued that those who report as being highly religious may conceptualise distress as more spiritual rather than of psychological aetiology (Bossley and Crosby, 2012). A qualitative study could be conducted in which this is explored. There are no studies that look at Muslim men in relation to help seeking behaviours and stigma associated within their faith and culture surrounding their psychological wellbeing in the UK. Past studies fail to look at the subjective views of these men in relation to stigma and mental health and how their faith possibly interacts with perceived stigma.

1.7 Identity process theory (IPT) and Muslim men's views on mental health issues

According to Sneed and Whitebourne (2003), a clear sense of self-definition or identity acts like a guide that navigates the individual throughout the stages of life. Individuals interpret their experiences through an identity schema which can also be altered by our experiences. Therefore, life experiences, along with age can cause some individuals to question their existing identities, particularly those of ethnic origin or children of first-generation immigrants (Sneed *et al*, 2003). Jaspal and Cinnirella (2012) suggest that identity assimilation and identity accommodation are the ways in which a dynamic equilibrium between the self and experiences are formed. The assimilation-accommodation process refers to the absorption of new information in the identity structure and the adjustment which takes place in order for it to become part of the structure. Sneed and Whitbourne (2003) further explain how identity processes have clear implications for understanding aging and mental health in adulthood.

Jaspal *et al* (2012) explore ethnicity in terms of its relationship with the motivational principles of identity and the impact of this for British south Asians. As the majority of Muslims in the UK are from South Asian backgrounds, it is important to understand how their identities impact their psychological wellbeing and if there are any "coping strategies" used by the participants to adhere to the removal or modification of a threat to identity. Jaspal *et al* (2012) have introduced the psychological coherence principle which refers to the motivation to establish compatibility between interconnected identities, which could possibly be an occurrence for the participants in this study. Furthermore, it has been suggested that the need to belong is an identity motive which refers to the need to maintain feelings of closeness to and acceptance by other people, which could possibly be difficult for south Asians and Muslims who typically come from collectivist cultures in which the opinions and views of the whole group are deemed more important than the desires of one individual.

To the best of my knowledge, prior to the 1940's, only a few systematic studies had been carried out in regards to public attitudes towards mental health. Furnham (1988) attempted to explore this phenomenon by investigating the possible reasons for individual and group differences in the structure and content of religious beliefs. The results of this investigation showed systematic features of the general population including their education, sex, age, class and religion having a significant influence upon their attitudes towards psychological beliefs. Furthermore, Favazza (1982) conducted a study in which Christians were asked what they believed the best practices to be for healing those with mental health problems; the results were that they understood prayer, scripture reading and support of their community as key factors for helping those with psychological distress. They also reported viewing mental health as being demon possession, based on the understanding that Jesus used to heal such people of these illnesses. The above studies being conducted in the 80's highlights how current literature is limited when it comes to exploring religious men's views and experiences of mental health problems.

Although there are no studies which specifically look at Muslims' thoughts of what they think and understand the cause(s) of mental health issues to be, Gow and Hartog, (2005) carried out research with 126 Christian participants who were assessed for their beliefs about the causes and treatments for major depression and

schizophrenia. The results indicated that the stronger the religious beliefs and less counselling/psychology knowledge, the greater the cognitive dissonance. Further results from this study showed that 38.2% of participants disagreed that mental illness might be the result of demon possession, 25.2% were neutral, while 36.6% agreed that mental illness might be the result of demon possession. 38.3% considered it unlikely that major depression could be caused by demonic influence, 23.64% were neutral and 38.2% considered it likely that major depression could be caused by demonic influence. 44.8% of the participants considered it unlikely that schizophrenia could be caused by demonic influence, 17.9% were neutral and 37.4% considered it likely that schizophrenia could be caused by demonic possession (Gow *et al* 2005).

It would of course be difficult to generalise the above study to the entire population as the sample were homogenous in terms of ethnicity, culture and the Christian faith. The participants' culture and origin may also be components that could have influenced the views of the participants in this study. Nevertheless, findings from Gow *et al* 2005 show that religious faith provides cognitive resources for interpretation and understanding mental illness. The authors have suggested that further quantitative and qualitative research should be explored between religion and beliefs about mental illness.

According to Badri, (2018), Muslim men may view their mental health problems as a result of the soul being in distress because of it diverting from its purpose of worshipping God. Worship can be defined as actions of the heart (including love), hope, submitting and hoping and trusting directly to God, seeking his help and calling on him. Physical acts of worship include fasting, praying and performing pilgrimage. Financial acts of worship relate to giving money to charity. Treating others with kindness and forbidding evil are also seen as acts of worship. The concept of the devil within Islam is that of an enemy towards Muslims who are trying to purify their souls. The devil is said to lead mankind astray from these acts of worship and instead persuade people to carry out and commit evil sins, however, the humans' free will is still accountable for its own actions. Therefore, some Muslim men may see their own illness as a result of their diversion from their relationship with God (Oman & Thoreson, 2003).

Khan (2007) carried out a cross-sectional study which was designed to describe subgroup variation in attitudes towards help-seeking behaviour. The aim of the study was to also determine perceived need for and use of counselling amongst Muslims in Ohio, Canada. 459 Muslims (44 African American, 240 Arabs and 119 South Asians) participated in said study by completing a self-reported questionnaire. Results revealed that all three groups considered prayer to be a regular source of comfort. The study concluded that age and gender were associated with the need for counselling, with older Muslims more likely to seek help than younger Muslims and with females more likely to seek help than males. The study showed that the majority of Muslims possessed positive attitudes towards counselling. Khan (2007) then goes on to explain that there is possible unmet need in the community with regard to discrepancy between reported need and reported under-use of service. If the results show that the majority of Muslims have positive attitudes towards counselling then why does this population not seek counselling when it is needed. To understand such a stance, the views of Muslim men's attitudes towards mental health should be explored and how they understand psychological wellbeing rather than just focusing on why they are not accessing the services provided.

In a bid to try and understand whether or not Muslims view their own values as being similar to the values that are proposed by counselling psychology, Amany, Eugene and Kelly (2008) surveyed 121 Muslims. The results showed that Muslims responded highly to the universal values of conformity and benevolence; low in power, stimulation and hedonism; they also scored high in humanistic mental health values. These results were compared with the results from the counselors surveyed and showed both similarities and differences between their values and that of the Muslim participants. Surprisingly, and in contrast to previous studies mentioned in this review, the results showed that the majority of Muslims were unwilling to attend therapy with a non-Muslim therapist but did show an interest in seeing a therapist who 'understood Islam' (Amany *et al*, 2008). More specifically, 52.9% participants responded that if they needed counselling they would prefer a Muslim counsellor, whereas 43.8% responded that either a Muslim or non-Muslim counsellor would be acceptable. If they had to go to a non-Muslim Counsellor, over 50% of the respondents said it was very important and another 25% somewhat important for the counsellor to have religious values similar to theirs. In any case, 56.2% considered it very important and 29.8% somewhat important for their counsellor to have an understanding of Islamic values.

Such research could be an insight into the ways in which Muslims view mental health professionals and mental health services. That the importance of their faith is a deciding factor for whether or not they will access mental health services and their beliefs about such services as well as the professionals involved. As the study by Amany *et al*, (2008) shows that half the participants would not be willing to see a non-Muslim therapist and over three quarters would want a non-Muslim counsellor to have an understanding of Islamic values, this emphasizes the need for non-Muslim therapists to develop an understanding and sensitivity to Muslims in a bid to engage with this demographic.

Chew-Graham, Bashir, Chantler, Burman, and Batsleer (2002) analysed data from four focus groups with Muslim participants and identified tensions between Western and Islamic understandings of distress. They also found that self-harm was a common coping strategy expressed by their participants, services were only used at the point of desperation and the perceptions strongly associated with honour impacted the decision-making process for seeking help and discussing mental health problems. According to Youssef and Deane (2006), evidence available has shown that despite a perceived need for mental health services, they are not being accessed by many UK Muslims. Studies have not only identified obstacles presented by the structures and values of health care institutions but describe the great contrasts in conceptualizations of the nature of mental distress, and the appropriate ways to address this within Western and Islamic cultures (Chew et al 2002).

Weatherhead and Daiches (2010) interviewed 14 Muslims and the results highlighted the interweaving of religious and secular perspectives on mental distress and responses to it. From this study, it was found that the majority of participants identified the cause of mental health or psychological difficulties as being a reaction to life-events such as stress, drugs, isolation, and repressing difficulties until they became bigger. In contrast to this, some of the participants identified mental health problems as being a punishment from God, or having a supernatural aetiology such as witchcraft or jinn; at times participants offered multiple perspectives on the causes of problems. Furthermore, religious and secular strategies, within and outside of therapy were identified as possible coping strategies. Participants spoke about prayer, or reading religious texts such as the Qur'an or Hadiths, or seeking guidance from religious leaders as a method of tackling the mental health issues. Some

participants said that they would feel ashamed, embarrassed, or stigmatized if they were to access services. Participants spoke of issues such as 9/11, Islamaphobia, and media representations of Muslims.

Furthermore, Weatherhead et al (2010) found that participants felt 'isolated' by statutory services, did not know how to access them or what services may be available. The participants discussed how they felt as though their religion would be an important aspect of therapy because it is a reflection of who they are. Participants commented that it would be helpful to train therapists from within the cultural group, because there was a lack of understanding of culture; at times, this was often also linked to their faith. Participants continuously examined how Western secular and Islamic religious beliefs could coexist. For some they remained mutually exclusive and seeking help from services would be considered a direct rejection of God. For others, mental health services and Islamic belief could be potentially complementary but a respect for and understanding of an individual's religious beliefs was seen as essential for the therapeutic relationship to be valuable. This research covered incredibly important aspects of Muslim's views on mental health, however, the participants were both male and female, came from various cultural origins and were both first and second generation; the sample size were not homogenous and perhaps the use of thematic analysis did not allow for a deeper analysis of data.

Ali and Humedian (2004) found that participants communicated the Muslim community's influential narratives of shame and stigma attached to the accessing of mental health services. Services were viewed as not being able to offer the dynamic of operating on two belief systems which was exemplified in participants' accounts of bullying and racism to the lack of information about services available in multiple languages. Despite the difficulties assimilating two belief systems for some individuals, and the sizable barriers to accessing meaningful services for others, there was an motivation in people's accounts to move towards a context where mental health services were truly inclusive, universal and accessible to everyone. The vision for the future was of integration, beginning with the availability of good quality information to the physical presence of mental health practitioners within Muslim communities. Regardless of whether participants had previously accessed mental health services or not, they were able to articulate characteristics of both the therapist and the therapeutic context that should be in place for therapy to be potentially helpful to them. Regardless of the religion of the therapist themselves, participants argued for the meaningful and respectful centrality of an individual's faith within the therapeutic process.

According to Cowie and Hayes (2005), there still remains a sceptical attitude and a level of uncertainty towards religion in regards to its place within the realms of psychology. In contrast to this, counselling psychology has began to take into account the significance of spiritual and religious experience of clients. Cowie *et al* (2005) argue that psychology and religion have constructive implications for the therapeutic progress. The influence of religion on client-centred therapy is evident in the emphasis of individual personal growth and the use of intuition and feelings as a guide instead of a doctrine. The argument is not that therapists need to be interested in the religion as such, but rather that they need to acknowledge and use the therapeutic experience as a bridge between psychology, religion and spirituality for their client (Cowie *et al,* 2005).

Ackerman, Ali, Dewey, and Schlosser (2009) discuss the lack of research on Muslim and Jewish clients. They state that in the USA, of all doctoral training programs, only 8% of the courses covered Jews as a distinct cultural group and only 2% of these courses presented Muslims as a distinct ethnic group. The majority of

training discussed Christianity when religion was explored as this was deemed a 'universal' religion. Such an underrepresentation of research and training at doctoral level could misinform therapists about the struggles that Muslim men face in their everyday lives, including mental health problems; therefore more research needs to be undertaken with these individuals if we want to follow the values of counselling psychology in aiming for inclusivity. Haque (2001) has found that despite historical animosities, there is an increasingly favourable interface between the two disciplines of religion and psychology and that given certain conditions this trend is likely to become stronger in the future.

1.8 Summary of the Review and Identified Gap in the Literature

As much of the literature in this review shows, religion can play an important part into aspects of psychology and engagement with therapy (Farooq *et al*, 2009). Some Muslim men may accept mental illness as a psychological phenomenon, they also may be hesitant to seek therapeutic help. Likewise, some Muslim men may view mental health as being in direct contradiction to their faith and will not seek therapeutic help. But for those who are not opposed to the notion of psychological wellbeing, it is not understood why they still do not seek counselling (Haque 2001). Is this from a source of stigma or is this directly because of how they view their mental health in the first place, and to what extent are their views influenced by their interpretation of Islam?

There is still a reluctance to seek the help; could it be because Muslim men believe that therapy will contradict their faith and go against their religious teachings. It is also interesting to note the lack of research in the UK when compared to the USA on Muslim men and mental health; similarly Muslim women are represented in studies more so than Muslim men.

With research and passages in the Quran directly mentioning and acknowledging psychological wellbeing; will Muslims, and do Muslims accept this awareness of mental health in the same way? And if not, then why not? With the Arab and Muslim world contributing to the development of psychology, mental health and psychiatry, why is there reluctance around seeking therapeutic help. In order to understand such a phenomenon, one must talk directly to Muslim men in order to understand how they view mental health from within the context of their faith and if they believe psychology to be in contradiction to Islam.

This review has looked at the possible roles that masculinity and Islam have on mental health, the stigma of psychological distress amongst Muslim men and the views of Muslim men on mental health issues in a bid to identify a justification for exploring Muslim men's subjective understanding of psychological wellbeing from the context of their faith in the UK. Such research could help professionals and Muslims understand and shift any misconceptions about the incompatibility of mental health within Islam and reflect up on what can be done to encourage help seeking behaviours with this demographic.

As mentioned earlier, previous research not only shows that Muslim men underuse mental health services and that very few studies have not taken into account generational differences or gender within Muslim studies (Tarabi *et al*, 2018). Most of the research focuses on the views of first generation Muslims and there is hardly any research on second generation Muslims, even though they make up half of the UK Muslim population

(ONS, 2011). As second generation Muslim men's subjective views of their mental health have never been explored, this leaves an important deficit in the literature which requires research in order to gain insight into this neglected group. This would need a qualitative approach exploring specific problems that Muslim men experience and how these difficulties are understood and related to their religious beliefs. Taking all of this into consideration, the following research question is proposed: How do second generation Muslin men experience mental health problems within the context of their faith? The study hopes to provide significant input in understanding Muslim men's experiences of mental health problems in a possibility to gain awareness into why they are reluctant to partake in help seeking behaviours. Such research would be consistent with the underpinnings of counselling psychology which are primarily focused on the subjective experiences of individuals and inclusivity (BPS, 2009).

1.9 Relevance of research to counselling psychology

As the Muslim population continues to grow in the UK, yet they underuse psychological services; providing this underrepresented group with appropriate psychological therapies needs to be focused on. There has been very little input thus far from counselling psychology research on Muslims and more specifically, Muslim men. As the underpinnings of counselling psychology are inclusivity of everyone and gaining knowledge of subjective experiences, counselling psychologists can contribute by exploring the subjective experiences of second generation Muslim men who have suffered from mental health problems (BPS, 2009).

Furthermore, counselling psychologists have the opportunity to contribute to the literature by providing research in scarcely studied areas to fill the gap between clinical practice and research (BPS, 2005). This proposed study aims to contribute an understanding for counselling psychologists of the experiences and challenges Muslim men face in terms of their mental health problems, this will hopefully lead to a better understanding of some of the reasons why Muslim men do not frequently access therapy and their possible thoughts around the aetiologies and alternative treatment options for mental health issues; these potential findings will help to better understand how counselling psychologists can contribute towards making therapy more accessible for Muslim men and how to engage Muslim men by acknowledging and being familiar with the possible religious and cultural dilemmas they face. Since Counselling psychology aims to contribute towards how differences and diversity can be addressed, give a voice to underrepresented client groups and improve the therapeutic alliance between therapists and clients, the proposed study thus coincides with the aims of counselling psychology research (BPS 2009).

Chapter Two

Methodology

This section will discuss the rationale for using a qualitative approach and an Interpretative phenomenological analysis method for this research. Additionally, the analytical process and ethical considerations will also be discussed herein.

2.1 Qualitative vs. quantitative methodology:

A qualitative approach was selected as it suits the aims of this research through its attempts to "investigate the person's grasp of their world in detail...developing a scientific understanding of the 'inner world' of experience" (Smith, 2015, p.5). In contrast to this, quantitative research is concerned with reducing the data to numerical values for statistical analysis in order to be able to generalise it to the wider population. The focus on the individual's personal experience, and the data being handled differently to that of quantitative methods, are the primary reasons that a qualitative practice will be most appropriate for this research (Smith, 2015). Qualitative research is a unique way of identifying common themes amongst data in research that has not been previously studied. The results from such research could then be used to further look at these identified themes from a quantitative stance. This section will uncover the epistemological and ontological stance and rationale of the researcher, the justification of using IPA, and important aspects of IPA such as phenomenology, hermeneutics and ideography – and how these stances relate to this particular research.

There has been some hesitation regarding the validity and reliability of qualitative methods such as IPA as different researchers would analyse the data differently, thus producing different outcomes (Kafle, 2011). Smith et al (2009) suggests that this can be rectified by having the data analysed by supervisors and professionals that are either involved with the research or are independent. I have kept a reflective diary throughout the research to be able to reflect on my personal beliefs, along with the use of personal therapy to further clarify my own thoughts in regards to this topic. I have also attempted to "bracket" (Smith *et al*, 2009) my own personal opinions, feelings and views to reduce the influence of my own biases up on the data. To ensure that my interpretations were grounded in the data, I submitted a random selection of interpretations to my peer researchers from various religious and cultural backgrounds. Furthermore, Smith *et al* (2009) suggests that the apprehension regarding the reliability of IPA can be overcome by having the data analysed by other professionals, which is a step that I took with this research; also, before moving onto another participant's transcript, I bracketed the themes off from the previous transcript in order to treat each transcript independently.

2.2 Epistemological and ontological stance and rationale:

From reviewing past literature, it became apparent that there was a gap in research on the subjective views of Muslim men experiencing a mental health problem; this stimulated many research questions aiming to obtain

such views. As the fundamental aim of the research is to explore experiences, and taking into account my own epistemological stance, IPA was considered the best form of analysis.

As a critical realist, I believe that there are different interpretations of the same or different reality as a result of individual perceptions. Although it is recognised that culture has a large influence upon one's understanding of their world, Smith (2015) would argue that this is a factor in the process of making sense of the world, rather than the absolute determining cause of this idea. The reason why IPA is then more in line with my own epistemological stance is because of its belief that meanings are constructed by individuals within both a social and personal world of their own. It acknowledges the important connection between an individual's thinking, speaking and emotional state.

Although the data analysis of IPA is arguably overlapping with that of thematic analysis, in the sense that they both use "themes" as a primary unit of analysis, thematic analysis has a less microscopic lens when interpreting data and generating themes and is often more preoccupied with themes that have been made at the 'group level', which is usually the first stage of IPA; IPA aims to establish micro themes which Smith (2015) has dubbed as "little pieces of experiential material" (Smith, 2015, p.8). Subordinate themes are made, finally followed by relationships between themes and Superordinate themes across all cases. Therefore, a single interview makes a large number of themes that have been looked at in great depth, due to the lengthier process of IPA when compared with thematic analysis. Although thematic analysis can effortlessly produce descriptive overviews of meaning to highly sophisticated interpretations, it can also be seen as a great starting point for research and perhaps does not dwell as deep into the meaning making process as IPA (Langdridge, 2007).

As this study requires an in depth look into the lived experiences and impressions of young Muslims from a subjective standpoint, it can be argued that this need can be addressed more appropriately with the use of IPA instead of thematic analysis, as IPA provides a much deeper scope of interpretation than thematic analysis (Langdridge, 2007). Furthermore, IPA incorporates a dual focus on the patterns of meaning made across participants as well as the unique characteristics of individual participants. In contrast, thematic analysis is traditionally concerned with the patterns of meaning made across participants. Furthermore, IPA provides a complete framework for conducting research, such as the specificity of a small homogenous sample, the encouragement of qualitative interviews and the research question focusing on people's individual experiences (Larkin, Watts and Clifton, 2006). In contrast, thematic analysis can be used widely across the epistemological and ontological spectrum, whereas IPA specifies its underpinnings as that of critical realism and contextualism. As this research is in relation to participant's lived experiences and perspectives, is a relatively small sample, addresses an experiential-type of research question with a phenomenological framework with the intention of remaining with an idiographic focus, IPA was deemed the most appropriate form of analysis (Larkin *et al*, 2006).

The epistemological stance of IPA coincides with that of my own in the respect that knowledge is gained through one's own understanding of the world around them, their own perceptions and thoughts shape their experiences. Therefore, the most effective way to gain this unique, individual experience is through asking the person directly; exploring their views and understandings of particular situations (BPS 2009). This is especially beneficial when trying to understand an understudied culture, religion or demographic as this is relatively

lacking in knowledge to begin with and through IPA, an in-depth analysis can be carried out, contributing to research areas that are sparse – the inclusivity of such research is a vital part of being a counselling psychologist and the values we uphold, in line with BPS guidelines (BPS, 2005). There has not been any research on Muslim men's experiences of mental health and how these experiences have been or have not been formed/influenced by their perceptions of their faith.

Grounded theory is an alternative analytical method to the study of lived experiences (Willig, 2013). Charmaz (2006) suggest that grounded theory requires data to reach saturation, and therefore a large sample of typically 8 to 12 participants in usually needed. Whereas, IPA's idiographic philosophy is focused on the individuals' experiences and is suitable for small sample size studies enabling a 'micro analysis' rather than a 'macro analysis' of data (Smith, 2015). Furthermore, grounded theory aims to explain particular phenomena through the use of an explanatory model with the intention of creating a theoretical analysis. Therefore, it could be concluded that rather than identifying and exploring personal experiences, grounded theory is concerned with the formulation of a theory or a model (Charmaz 2006). This study does not seek to formulate a theoretical explanation of these experiences, but instead it aims to explore second generation Muslim men's personal lived experiences of mental health problems in order to gain an understanding into those personal experiences. The aim and objective of this study is thus in line with the philosophical and epistemological underpinnings of IPA methodology (Smith, 2006), and IPA was therefore identified as being more appropriate than grounded theory. Similarly, the positivist epistemology has been rejected as a possibility for this research as its beliefs stem from the view that knowledge is created from obtaining and analysing scientific data only; this seems to suggest that positivism lacks the value of subjectivity which does not coincide with IPA and or the principles of a CoP which are that individual experiences are unique and cannot be generalized.

2.3 IPA

IPA was developed in the 1990's and in this respect is a fairly new analytical approach. With its main usage historically being in the fields of health-related research, it is now being utilized in all areas of psychological studies because of its ability to produce in-depth exploration of intersubjective experiences in previously unexamined populations. Although recent, its origins and main concepts stem from that of deep-rooted ideas such as hermeneutics and phenomenology (Kafle, 2011).

Phenomenology is an umbrella term referring to a philosophical movement which originally focused on consciousness and essences of phenomena towards elaborating existential and hermeneutics and encompassing a research approach; this was first initiated by Husserl. Heidegger, a student of Husserl's then moved the theory towards interpretative dimensions. Phenomenology is about the experiential reality of life, an approach that understands the hidden meanings and the essences of a particular experience; a method in which the experiences of select individuals are focused upon (Kafle, 2011). Therefore, the concern of IPA is to examine, in great detail, the lived experience of an individual and how the individual makes sense of that particular experience. As well as evidence-based practices, CoP relates itself to phenomenological models of enquiry, allowing it to naturally fit with the BPS (2005) concepts which promote intersubjectivity and subjectivity (Flowers, Larkin & Smith,

2009). According to Flowers *et al* (2009), the phenomenological philosophy provides counselling psychologists with a rich source of ideas in relation to how we can examine and attempt to understand lived experience.

Hermeneutics is the second major theoretical underpinning of IPA (Charmaz, 2006); it is the theory of interpretation, which is of course the essence of IPA (Willig, 2013). Schleiermacher was one of the first to write about hermeneutics systematically in which he discussed interpretation as a holistic concept, needing both grammatical and psychological involvement when it comes to interpretation. Following influence from Heidegger, there were more concerns with understanding how a phenomenon appears (Willig, 2013). The researcher plays a crucial role in the facilitation and making sense of this phenomenon. The researcher is seen as having a dynamic role where a dual interpretation, called double hermeneutic, is used as a process; this refers to the acknowledgment that participants are trying to understand and describe their world whilst the researcher is attempting to understand the participant trying to make sense of what is happening to them (Willig, 2013). IPA uses a style of empathic and questioning hermeneutics, where the researcher attempts to try and understand what is being experienced from the participant's view and what they are trying to achieve and also what they may be unaware of (Willig, 2013).

A fundamental aspect of IPA is the detailed, in-depth analysis involving the understanding of how particular phenomenon are experienced and understood by a specific group of individuals in specific situations (Smith, 2015). Idiography focuses on transferability rather than researching for the purpose of generalisability (Willig, 2013). Idiographic methods focus on the interpersonal and personal, individual experience of an individual which cannot be explored as thoroughly through the use of quantitative methods (Smith, 2015); this is reflective of the CoP stance that aims to explore subjectivity of individuals (BPS, 2005). IPA was considered a suitable method as it fits with the epistemological stances of the research question which is to explore the subjective experience of Muslim men who have faced a mental health problem. Counselling psychology is concerned with the importance of understanding the individual's subjective experience and the uniqueness of this, which mirrors the principles of IPA (Strawbridge & Woolfe, 2010).

According to the BPS (2005), counselling psychology practice guidelines encourage choosing research methods that are congruent to the values underpinning the discipline. Counselling psychology takes a pluralistic view that incorporates the inclusivity of people from different beliefs, experiences, views and cultures. Therefore, the researcher's personal philosophy is to appreciate the subjective views of individuals, as the profession is that of a counselling psychologist. Coming from a Pakistani background and with a strong Muslim upbringing, has influenced the researcher's epistemological position, which is that of a social constructionist; this is likely due to the consideration of culture and context of experience that this stance embraces. Perhaps this has then influenced the researcher's choice of IPA for analysis of data, as this method would allow the researcher to reach into the world of others and allow for the discussion of what meaning the participants hold of their individual and unique experience.

IPA was also used as it is an exploratory method that can be used for topics that have been under-researched, such as this research. IPA was also used for this study as it allows for the capacity for the researcher to acknowledge and use their own meaning of their participants' experiences (Smith, 2005). The pluralistic

paradigm is rooted in humanistic, person-centred and post-modern principles (Cooper & McLeod, 2010). It is in opposition to the modernism view that claims there is one unifying answer to a question. The post-modern view suggests there are multiple answers depending on cultural, linguistic, political, personal and social factors. The analysis used which incorporate idiography must be thorough and systematic according to Flowers *et al* (2009) - "The result of such research is that individuals can offer us a personally unique perspective on their relationship to, or involvement in, various phenomena of interest" (Flowers *et al*, 2009, p29).

2.4 Materials:

To identify and monitor risk, the PHQ-9 psychometric measure (Appendix B) was selected as it has proven to be a reliable indicator of potential risk of suicide or self-harm for individuals. Risk to the participants was anticipated as they had not received treatment for their mental health problems and were not under the care of any service. The participants had access to their GP's, but this alone did not seem to be enough to assess whether or not there might be a risk. PHQ-9 as used to make sure that participants joining the research were not "moderate" to "severe" on PHQ-9 and that they did not select the highest numerical value for question nine on the questionnaire which is in relation to thoughts around suicide or self-harm. All participants scored "mild" in accordance to the scale used and no participants scored more than zero for question number nine. All participants were able to take part in the interview.

An interview schedule (Appendix E) was created using the guideline provided by Flowers *et al* (2009). The interview schedule provided a somewhat flexible structure to open-ended exploratory questions. The interviews began with more general questions around the topic of faith and what Islam means to the participants as well as their knowledge and understanding of mental health. Other factors influenced the structure of the questions, such as discussions with my peers about the research, discussions with family members and other Muslims around the research in general, the literature read during the research process and supervision with my supervisor. It was important to use open ended questions as they allowed the participant the opportunity to ease into the subject matter and familiarise them with the interview process as well as me, the researcher; I then proceeded to ask more specific questions (Smith, 2015). A voice recorder was also used during the interview as well as a room at London Metropolitan library, MIND Milton Keynes and participants' homes. Other materials used were recruitment posters (Appendix A), information sheets (Appendix C), consent forms (Appendix D) and debriefing forms (Appendix F).

2.5 Inclusion/exclusion criteria:

Participants would have to meet the following criteria to partake in the research:

- Muslim
- Male gender
- Current or previous experience of a mental health problem
- Between 18 to 65 years of age
- British born, second generation
- No previous therapy

As IPA requires a homogenous group of participants, such purposive sampling is in line with recommendations to create a unified sample (Smith, 2015). As stated by Utz (2011) and various other literature, Muslim men under-use psychological therapies, which reflected the difficulty in recruiting such participants. In order to aid my search, I did not specify a particular mental health problem but I did make it a criterion to only see Muslim men who have not previously received therapy. Additionally, so that I could recruit a feasible amount of participants, an overly restrictive inclusion criterion was not implemented as this may have obstructed recruitment. Seeing Muslim men who have not had therapy means that I would be able to get the perspective of Muslims who do not engage with psychology in order to understand this aspect of their lives as well – specifically, why they do not seek therapeutic help along with the influence of their beliefs on their views of mental health. Muslim men who are in therapy or have had therapy may have different beliefs about mental health and their help-seeking behaviours but I wanted to understand the majority of Muslim men with mental health problems who are not accessing therapeutic services.

2.6 Procedure:

Recruitment posters (Appendix A) were placed at MIND in London and urban areas in Bedfordshire libraries, universities and on social media sites (Facebook and Instagram) where they were also requested to be shared in order to utilize the snowball technique of sampling. In total, seven participants contacted me with their interest in this research; all seven participants were suitable for the study according to the PHQ-9 scale. The seven participants were met on different days and at various locations in order to ease the process for them. Three participants were met at London metropolitan university library, two were met at MIND, one was met at his local library and one was met at his home. All participants were given and I talked through the information sheet with them and answered any questions. The consent forms were signed, the recorder was turned on and the interview began, using the interview schedule as a guide. The participants were then debriefed, any further questions that they may have were answered and they were thanked for their time and participation. Each interview was downloaded and stored in password-protected files on my personal computer after completion. The recordings will be destroyed once they are no longer needed for further research or publication purposes.

2.7 Participants:

Seven Muslim, male participants aged between 20 to 34 met the inclusion criteria and took part in face-to-face interviews. All self-reported as being practicing Muslims who were born in the UK and are second generation. All participants were familiar with the basic teachings of Islam and had some knowledge of their faith in the context of psychology. None of the participants had any experience of receiving any therapy prior to the research interviews. The participants were from various ethnic backgrounds and presented with either depression, anxiety or PTSD – a criteria for this research was that these mental health problems

Table 1: Summary of participant's demographics:

Name	Age (years)	Occupation	Ethnicity	Presenting problem
Musa	26-30	Unemployed	Arab	Depression
Adam	26-30	Data analyst	Pakistani	Anxiety
Yousuf	26-30	Banker	Arab	Depression
Mohammad	20-25	Retail worker	Indian	Depression
Rashid	31-35	Manager	Bangladeshi	Social anxiety
Ibrahim	20-25	Student	Pakistani	PTSD
Shams	26-30	Personal trainer	Pakistani	Anxiety and Depression

2.8 Data Analysis:

The interviews were listened to a numerous amount of times, I noted any thoughts, memories or reflections that were created in order to help me familiarise myself with the data (Flowers *et al*, 2009). The seven interviews were then transcribed verbatim. I then listened to the interviews again whilst reading the transcript to allow for the possibility to make any required amendments to the transcript, thus ensuring the accuracy of the participant's subjective experience. The next stage of analysis entailed making initial notes which focused on the semantic content and the way that the language was applied by the participant. This stage was about trying to be able to recognise the ways in which the participants talk about, understand and think about the relationships between Islam and psychology/mental health.

Exploratory comments were then noted in the left-hand column of the transcripts, exploring the descriptive and conceptual comments. The next stage involved identifying and developing emergent themes which were noted in the right-hand column of the transcript, this stage focused primarily of the exploratory comments made rather than the transcript itself. The themes were the product of what the participants said but also that of the researcher's interpretation of what the participants said – the emergent themes were abstract and grounded within the text, linking them to psychological concepts and theories.

The next stage involved identifying possible links between the emergent themes by writing them down and visually trying to see any emergent patterns. This process helped to see similarities and differences between themes. The similar themes were given a descriptive label that communicates the conceptual nature of the themes. This process was repeated for all participants' transcripts. Before moving onto the next transcript, I consciously remembered to treat it independently from the previous transcript, to the best of my ability as this allowed for new themes to develop. The final stage of analysis involved identifying patterns across the cases. This was done by laying out the four tables and looking across them (Smith et al, 2009). Some themes were relabelled or changed at this stage. A master table (table 2) was then created which illustrated the final superordinate and subordinate themes. Each subordinate theme is being supported by four quotes in total from across the seven transcripts.

2.9 Ethics

Prior to any research taking place, ethical approval was gained from the Research ethics committee at London metropolitan university (LMU). The study was carried out in accordance with the BPS's ethical guidelines (BPS, 2009). This study did not involve the deception of participants; there was no withholding of any information from the participants. Furthermore, participants were briefed, in detail, about all aspects of the research and interview process before they signed the consent forms. One copy of the signed consent forms was given to the participants and the second was kept by the researcher. Participants were advised that they could discuss as much or as little as they would like during the interview stage. At the end of every interview session, participants were also given the opportunity to discuss any possible concerns. Participants were aware that they could withdraw from the study within the four week period after the interview. Participants were also advised that the interviews would be audio recorder and were given the opportunity to address the researcher with any concerns about this; no participants objected to being audio recorded.

Participants were told that pseudonyms would be used throughout the study to ensure anonymity in published work or for articles in wider publication. All identifiable information was removed or changed to protect confidentiality (Smith, 2015). Participants were informed that the information they shared in the interviews would be kept confidential, their identity would be protected, and kept anonymous. All data was kept in a safe and secure place at the researcher's home in a locked filing cabinet. Audio recordings were password protected. The interview material will be retained for five years after the completion of the study, and all the data was processed in accordance with the Data Protection Act (1998). Consent forms were kept apart from the transcripts and participants have been identified by a separate code, which is only accessible to the researcher.

As participants were disclosing personal information during participation in the interviews, by recalling and disclosing information about their experience of therapy, it was important to have a risk plan. It was not anticipated that the participants would experience any distress but the researcher was continually monitoring the participants' emotional and psychological state throughout the interviews. As a trainee counselling psychologist, the researcher had skills and experience of supporting individuals with psychological difficulties, which aided the researcher in being able to unpack the depth of the participants' experiences whilst ensuring their safety. If a participant became distressed or experienced a panic attack during or after participation in the interview, a distress protocol (Appendix G) would have been followed. I would have intervened and informed the participants that they can withdraw from the interview at any time and would have then carried out a debrief immediately. The risk plan was not needed. Participants were provided with a list of therapeutic services available to help support them; they were also recommended to contact their GP in regards to their mental health problems if a participant was particularly distressed. Both the researcher's and the research supervisor's contact details were provided to each participant, if any of the participants had any questions or concerns about the research.

2.10 Personal reflexivity

In qualitative research, the interactions between the researcher and the participants are seen as having an influential effect on the research. I had made assumptions about the participants prior to meeting them and during the interview process. I assumed that the participants would be under the impression that Islam and psychology are compatible as I was aiming to find Muslims who shared my views. I was prepared to have interview sessions with patients who disagree with my perspective that it is possible to be a practicing Muslim and also seek therapeutic help or even recognise that mental health problems exist. However, none of the participants disputed the existence of mental health problems and therefore I did not encounter anyone who opposed my own beliefs. I was also under the impression that the Muslim men might not want to talk to me as I am a female or that they might have judged me for not wearing a headscarf, however, all of the participants engaged well with the interview and no one made a comment on my appearance or religiosity. It appeared that the participants were grateful that they were just able to discuss problems that they have not had the opportunity to do so before.

However, I was also aware that perhaps the participants' agenda was to be able to discuss what they might not have previously had the opportunity to do. Therefore, it could be likely that the participants might have discussed mental health problems from a perspective that they thought I would want to hear. As they were aware that I was a trainee counselling psychologist, there might have been the belief that they have to share views that are supportive of mental health. If met with a different researcher, the participants could have responded differently to the interview questions.

Chapter Three

Analysis

The IPA analysis looked at what was said by the seven participants, and the researcher's interpretations of this. Three super-ordinate themes emerged:

"**Perceived stigma from community**", "**Mental health issues as seen from an Islamic perspective"** and "**Intergenerational conflict and masculinity within Islam**".

The superordinate theme "**Perceived stigma from community**" looks at the influence that the thoughts of other Muslims and cultural community members has upon the inability of Muslim men to openly discuss their mental health problems or seek therapeutic interventions. The next superordinate theme "**Mental health issues as seen from an Islamic perspective**" denotes the overview of Islamic interpretations in relation to the possible causes, treatment and guilt in relation to the mental health problems. The third super-ordinate theme "**Intergenerational conflict and masculinity within Islam**" discusses the roles that Muslim men believe they have to adopt in order to respond accordingly with their cultural expectations as well as their views on the generational differences between themselves and their parents. Each super-ordinate theme will be discussed in detail, with reference to the sub-themes that make up each theme.

3.1 Table 2: Summary of Themes Formed Through the Analysis Process

Superordinate themes	**Subordinate themes**	**Quotations**
Perceived stigma from community	It would look bad	"It's such a taboo subject that I wouldn't want to talk about it with anyone I know because that's not the normal thing to do and it might affect the way people would look at me." *(Adam, P2, 41-46)*
	Therapy can't help	"The community would say, what even is therapy in the first place? Therapy can't help" *(Yousuf, P7, 277-278)*
Mental health issues as seen from an Islamic perspective	Betraying God	"I'm not relying on God alone to help me and that I'm betraying Him somehow" *(Yousuf, P7, 297-298)*
	Devil or Jinn influencing you	"Around something evil going on, like an evil force getting you…like the devil maybe or a jinn that might be influencing your decision-making and state of mental health" (*Rashid, P5, 178-179)*
	Alternatives to therapy within Islam	"I think the imam would pray with the person who is poorly near them…and then the jinn or whatever would leave the person's body that way…and this should make the person then feel better" *(Mohammad, P8, 300-302)*
Intergenerational conflict and masculinity within Islam	Man is the head of the house	"There's an idea about masculinity in Islam, which is basically that the man is the head of the house, he should be working and earning money for his family" *(Yousuf, P7, 308-310)*
	Thinking differently to the first generation	"I spoke to him about being overly aggressive towards me, I was 22 and I just blew up and all the anger inside me just came out. He obviously didn't respond to that very well… I kept bringing up situations like why did you reduce me to tears over these small things? And being a Pakistani, he was first like who do you think you are telling me this? It was a tough barrier that I first had to break through" *(Shams, P9, 305-315)*
	Men hiding their problems	"I still react how most Muslim men would, by not discussing it with our families" *(Musa, P3, 83-84)*

3.2 Perceived stigma from community

This super-ordinate theme examines the scrutiny that Muslim men may go through when talking about mental health or seeking therapeutic help. It looks at the negative consequences and possible perceptions from within the cultural and religious communities which affect members of their own faith.

Two sub-ordinate themes are presented: "**It would look bad**" and "**therapy can't help**"

It would look bad.

The reputation and image of individual family members becomes the collective reputation of the entire family. Therefore, the importance of maintaining this status is reflected amongst the participants in this research and how the possible revelation of a mental health problem may not only affect the individuals suffering, but also the impact that this declaration may have on the entire family.

As a whole, the interviews suggested that the comments and thoughts of members of the community made a significant impact upon the participants' perspective and likelihood to discuss mental health with their family members as well as their likelihood to seek therapy.

The repercussions of this phenomenon are the ideas that pursuing therapy might bring shame on the family, suggesting that engaging with active discussions around mental health are an unlikely occurrence within these familial and community dynamics.

Musa felt that the Arab community would judge him for discussing mental health problems:

> *"I think they'd judge me for it, the Arab community…It would look bad for my parents" (Musa, P6, 199-201)*

Interestingly, Musa speaks about being judged by the Arab community, rather than the Muslim community, this could suggest that the perceived judgement comes from within a cultural context rather than a religious one for Musa. Furthermore, the word community suggests a vast amount of people, rather than a few individuals. This could be quite a daunting and intimidating prospect, the notion that many people are judging Musa if he should share his mental health problem, is understandably a justifiable reason for him to not want to discuss mental health with other Arabs. It could also suggest that the community is very cohesive, and if one member of the community finds out about him having a mental health problem, then this could mean that other members of the same community would also find out and collectively judge Musa.

The word judge could also suggest that he may feel as though the thoughts of the community have a powerful influence and affect over Musa's likelihood to share his problems with mental health – in comparison to when a professional, legal judge has the right to make a decision for the lives of others. It gives the impression that the opinions of the community and the reaction from others has made it less likely for him to talk about mental health problems openly, without feeling as though his familial reputation would also be impacted.

This could suggest that Musa feels somewhat responsible for the way in which other members of the Arab community view him and his parents, but also that the actions of one member of the family talking about mental health could have a negative impact upon the other family members, indirectly. The idea that this collectivist culture affects the ability of Muslim men to share their mental health problems is prevalent across the interviews. Similarly, Adam also expresses the idea that mental health is not discussed openly within cultural communities:

> *"It's not exactly something that the Asian and Muslim communities openly talk about, so it's not the main topics of concern…It's such a taboo subject that I wouldn't want to talk about it with anyone I know because that's not the normal thing to do and it might affect the way people would look at me." (Adam, P2, 41-46)*

Adam also recognises the lack of recognition of mental health problems within the Asian community but unlike Musa, he also speaks about the Muslim community's stance towards this area. The word taboo could suggest that mental health is unspoken of and the mention of it could lead to ramifications. The idea that this topic is prohibited or restricted and that the discussion of it could lead to consequences, could be a valid reason for Adam, like Musa, to avoid talking about their mental health problem with other Asians and Muslims. Furthermore, Adam also recognises the effect that their self-disclosure could have within the wider community as this would affect the way people would look at him – that such a revelation would change his image or identity amongst others from within the same community. The rarity of such a discussion is highlighted when Adam states that it is not normally discussed.

Not only do the opinions of the wider community impact the lack of confidence of Muslim men sharing their mental health problems with each other, but according to Yousuf, it also affects the likelihood of them seeking therapy:

> "Most of the time it's just this thought or feeling of what will other people think if you went to therapy?" *(Yousuf, P6, 264-265)*

Mentioning feelings as well as thoughts could suggest that the opinions of the community affect Yousuf's emotions and cognitions. The thoughts of what others in the community are thinking is again, a reason why Yousuf may find it difficult to seek therapeutic help. Again, this also highlights the idea that if one person went to see a therapist, then this would be quickly known of throughout the rest of the community, suggesting that actions and behaviours might have to be carefully executed based on the thoughts of others and how this could potentially reflect poorly on the individual.

Rashid also makes reference to problems and mental health not being discussed within the communities:

> *"Just be able to talk to a few people that you trust about what you are going through…I do think it's annoying that this is the way it is in the Asian and Muslim communities and unless you are aware of the barriers, you will just carry on doing what you think is right by not talking about your problems and just burying all of your problems." (Rashid, P4, 128-131)*

However, Rashid recognises that there is a barrier in place when not discussing mental health and he actively strides towards discussing his mental health problems with close friends despite the stigma around this topic. This also possibly allows an insight into the consequences of what happens when Muslim men do not speak about mental health problems as a result of the community judging them for it -Rashid suggests that the way that he and possibly other men may deal with everything is by hiding their problems.

Therapy can't help.

As the opinions of members of the same cultural or religious backgrounds can be important for Muslim men, this notion also affects the ability of the participants to be able to seek therapeutic help. There are overlaps between the participants' experiences of stigma around therapy.

> *"If one person knew about me going to therapy…there's a lot of stigma around it… I think it would be difficult for someone who's not Muslim or who's not from an Arab background to understand how hard it is to ask for help." (Musa, P6, 217-218)*

Musa suggests that if one person finds out about him going to therapy, then everyone in the community will find out. He also confirms the stigma around this but further goes on to explain how he thinks it would be difficult for a non-Muslim or non-Arab to understand why seeking help is so difficult – this implies that Musa may find it hard to seek therapy because of the stigma, but also makes me wonder if the mention of non-Arabs and non-Muslims makes him feel further misunderstood and isolated. The feeling of not being able to discuss mental health with individuals from your own culture and religion could be a challenging obstacle for Muslim men, but in addition to this it seems that Musa may feel additional hindrances in seeking help, for not only is there perceived judgement from within his own community, but there might also be perceived judgement from individuals from different faiths and cultures which may affect Musa's ability to seek help.

Some of these thoughts are reflected in the dialogue with Yousuf:

> *"The community would say, what even is therapy in the first place? Therapy can't help" (Yousuf, P7, 277-278)*

The way Yousuf mentions the community almost makes it sound like the community are an entire entity or power of their own. That the image he has of the community is of a unit or a whole rather than a fusion of different individuals. "The community would say" suggests that the community speaks as a group, that the thoughts of individuals are perhaps overlooked or inadmissible which could be a rather intimidating situation to experience if you are on the opposing end.

Furthermore, Yousuf also reveals his thoughts around members of his own culture and religion not understanding what therapy is and that it cannot help – these could also be possible reasons as to why Yousuf would feel as though he is going against the community's views as therapy is an unknown subject, and from my experience of being from an Asian and Muslim cultural background, new customs and practices are often dismissed as they could affect the traditions of the culture. The maintenance of the traditions are usually the

main priority and need to be upheld which is the reason why the topic of therapy might be so easily rejected as it could allow the possibility of new beliefs, which are interpreted as being a threat - this is verified further by Yousuf:

> *"If culture has ever taught me anything, it's that no one within that culture likes change or the introduction of new ideas, because that affects the traditions of the culture." (Yousuf, P7, 301-303)*

Not only is therapy misunderstood and unrecognised within the community, Adam identifies other views around therapy from within the community:

> *"Why are you wasting money on this? Why are you talking to a stranger? You should be talking to God" (Adam, P6, 197-198)*

People saying that therapy is a waste of money could imply that therapy is not seen as a reliable or worthy form of treating mental health problems. Talking to a stranger could suggest that the opinions of others outside the community might not be welcomed neither appreciated. The word stranger in this context is used to describe someone who is not from the Asian or Muslim community – this suggests that therapists may be seen as outsiders who are not welcome, leaving Adam in a paradox of not being able to talk to the community members or therapists as there are implications around being judged by both. It sounds as though there might be some judgement around Adam's level of religiosity, as this reminder to ask God for help is imposed. Rather than talking to a stranger (the therapist), Adam should be seeking help from a higher power, God – this could mean that God is seen as being the solution to mental health problems and that talking to a therapist is frowned upon either because it is seen as being ineffective or therapy is seen as something that is trying to usurp the position of God, which could be seen as being blasphemous.

3.3 Mental health issues as seen from an Islamic perspective

This super-ordinate theme explores the possible Islamic views on why Muslim men have mental health problems. There are matters regarding the participant's guilt around having a mental health problem and feeling as though this is caused by their levels of religiosity and connection with God, the idea that the devil or the jinn are causing mental health problems and the possible "Islamic" remedies for mental health problems that could be seen as a substitute to therapy. Overall, this super-ordinate theme would focus on the possible influence that Islam would have on the causes and possible treatments of mental health and how these participants interpret and make sense of both their religion and mental health.

Three sub-ordinate themes are presented: "**Betraying God**", "**Devil or jinn influencing you**" and "**Alternatives to therapy within Islam**"

Betraying God.

There are many different aetiologies when it comes to mental health problems, it appears throughout these transcripts that there is a notion that these issues could be caused as a result of religious neglect. The participants' piety could be questioned as a result of them feeling depressed or anxious, which could possibly contribute to the idea that the mental health problem is the participant's fault and that their mental wellbeing is in their control. More specifically, there are overlaps in relation to the connections that the participants believe they have with God and how this could be paramount in causing problems. Yousuf expresses the following:

> *"I'm not relying on God alone to help me and that I'm betraying Him somehow" (Yousuf, P7, 297-298)*

Yousuf articulated an internal sense of guilt when it came to his mental health problem. The word rely could suggest that there should be a sense of loyalty and dependence on God. 'Alone' implies that perhaps other sources of help should be shunned and God solitarily should be the main source of help – this leaves little to no room for the intervening of therapists or even family members and friends. 'Betraying' gives a feeling of forsaking or abandoning God if other forms of help are pursued – if someone values their relationship with God, and believes this idea, then this thought could be enough for them to avoid seeking help from any other source, such as therapy.

Musa also ponders the idea that mental health problems are caused by a weak relationship with God:

> *"The reason for a mental health problem like depression might be because the person is not as religious as they should be" (Musa, P4, 116-117)*

After saying this, Musa looked upset, to which I needed to clarify if he was okay and needed a break, but he said he didn't require a break and proceeded to explain the following:

> *"Got a bit upset there because I just thought maybe I haven't been praying or remembering God as much as I should...I feel Guilty, upset for not remembering God as much as I should. Maybe that would even make me feel better. But then I think, it won't change the fact that my wife and kids aren't living with me anymore." (Musa, P4, 125-127)*

There was a moment during the interview, when it appeared as though the guilty feelings overtook Musa, particularly when he first mentioned the possible cause of his depression. He specifically mentions prayer and remembering God as acts of worship, suggesting that not carrying out these rituals may have led to his depression. However, the word 'maybe' suggested that he was unsure of the extent to which he believes what he is saying. This uncertainty is further clarified when he suddenly appeared more composed during the interview and then suggested that even if he did pray and talk to God, his wife and kids would still be gone - he believed that this was the primary reason for his depression and mentioned life events as being a factor towards his depression.

Perhaps his thoughts that mental health problems and depression are caused by a lack of remembrance of God are present but only to a certain extent and could be the result of his upbringing. When he seemed to recall what other possible reasons there could be for depression, he managed to dismiss the idea that his depression is

caused by his relationship with God and that praying would not rectify his life problems. It could be that his concept of prayer is therefore around remembering God rather than being able to ask him to return his wife and daughter to him after his wife moved out – or it could be suggested that he feels too guilty to ask God for assistance with his wife and child as he neglects his remembrance of God and prayers.

Not only have these participants expressed their views on potential causes of mental health problems as being a strained relationship with God, Adam discusses another potential reason for his anxiety problems:

> *"She (mum) said I'm in my late twenties and that God might be punishing me for not marrying by this age as it's a religious obligation…So yeah, there's also the concept of God punishing you and that's why you might have a mental health problem, I think that's crap. Sorry for the language. But I think Muslims should not be blaming each other for their mental health problems or making each other feel guilty." (Adam,P5, 174-180)*

The theme of betraying God is continued here with Adam's mum suggesting that he is being punished as a result of not being married. This could imply that mental health problems, such as Adam's anxiety are his own fault, which could lead to more anxiety. It was refreshing to hear Adam say that he disagreed with his mother's opinion about this theory and his acknowledgment of the concept of God punishing him being a cause of guilt rather than aiding his difficulties suggests that he is able to reflect upon and challenge the beliefs of his parents.

Devil or Jinn influencing you.

This subordinate theme covers the participants' views on other life-forms interfering and influencing the psyche and possibly causing mental health problems, or at least contributing towards them. The Jinn are beings that are made of smokeless fire that are able to appear in human and animal forms and are thought to be able to possess humans. The devil in Islam is a Jinn who disobeyed God and was in turn banished from heaven and swore revenge on mankind. Adam discusses this further:

> *"Or they might think it's something to do with the devil. He has the capability of making people feel angry, depressed or negative so I guess he also has the ability to make people feel anxious– I actually agree with this but for other people. I don't think this is what's causing my own anxiety." (Adam, P4, 85-87)*

Adam starts by using the word "they", suggesting that these beliefs are the thoughts of others. However, he ends this statement with confirming that he himself agrees with this theory. He specifically describes the feeling of anger being associated with the devil but also depression and anxiety – perhaps this is because placing the blame on an already disgraced figure in Islam, such as the devil, makes the process of having a mental health problem slightly easier to deal with and accept. Associating the mental health problem with a cause might also provide further information such as the way in which to treat the problem and eradicate any uncertainty. Mohammad further explains the perceived ability of Jinn on mental health symptoms:

> *"They (Jinn) are inside the person, they can make them feel really negatively and think really badly about themselves maybe…they can make people go mad, make people argue with each other and cause problems between people…they can affect someone's mental health then, if they have the power to do all of that…but yeah when some people say they can hear voices or whatever, I think that's a jinn possessing them and that's the jinn's voice that they can hear but doctors and stuff will think the person's crazy or whatever. It's kind of sad actually" (Mohammad, P6, 229-235).*

The symptoms that Mohammad describes as being the result of Jinn possession are quite similar to that of depression – feeling and thinking negatively and becoming irritable quickly. This could then imply that whenever anyone displays these symptoms, there could be a possible suspicion of Jinn possession. It feels as though perhaps Mohammad knows that these are also symptoms of depression which is why he says those symptoms can affect someone's mental health. The mention of the word power implies that Mohammad gives the jinn a large amount of capability. Associating the Jinn with power and the ability to influence our thoughts, feelings and relationships with others as well as our own control over our potential anger suggests that these beings are seen as being very controlling and influential.

Furthermore, Mohammad then suggests that auditory hallucinations are also a side effect of jinn possession. He simultaneously suggests that the hearing voices are somewhat misdiagnosed by doctors as being a mental health problem, which he addresses as 'mad' or 'crazy'. He does not refer to other mental health problems as mad or crazy, in fact, he addresses his own depression as an illness. This implies that different types of mental health problems are seen contrarily in terms of their aetiology and interpretation, whilst also suggesting that the doctor is somewhat unreliable as they have diagnosed incorrectly which could imply that the status of mental health professionals could be questionable. Mohammad describing this situation as being 'sad' could be slightly patronising as it sounds as though he is calling the 'misdiagnosis' as being sad, rather than the hypothetical situation of suffering from auditory hallucinations.

> *"Around something evil going on, like an evil force getting you…like the devil maybe or a jinn that might be influencing your decision-making and state of mental health" (Rashid, P5, 178-179)*

The above statement from Rashid reflects the thoughts of some of the other participants in the sense that he also believes that the devil or jinn are influencing people's psychological state of wellbeing. Rashid mentions the word evil twice, which could perhaps indicate that the mental health problem is also something evil or even possibly unholy. "Force getting you" insinuates that maybe the jinn are strong creatures, from whom there is no escape - almost as though they will possess a person if they should wish to do so, with minimum effort.

As the Jinn are mentioned frequently in the holy book, the Quran, the views of these participants believing that the devil or jinn impacting or even causing mental health problems could be linked to the views of Islam, but also to each individual's cultural influence. All participants that spoke about the devil or the jinn in relation to mental health problems spoke about this in terms of symptoms that are similar to depression and anxiety. Such theories around mental health problems and the jinn are reflected in the hadith (religious texts) which speak about the very same symptoms described by these participants. Perhaps these views are one of the reasons why Muslim men would also fear sharing their problems with others from within the same community, as they may

view their presenting problems as being caused by Jinn rather than a mental health issue. Mostly, there is also a stigma around being possessed as there is often a notion that perhaps the jinn possession occurred because the individual was neglectful of their faith, which adds to the controversy.

Alternatives to therapy within Islam.

The participants gave similar views when it came to what they thought could potentially reduce their symptoms caused by their mental health problems. It is important to note that the perceived causes of mental health problems were crucial when it came to the participants generating ideas around what they believe the remedies to mental health problems could be. They explored the substitute options to therapy that they believed would be best for dealing with mental health issues, with influence from their Islamic interpretations of what might be recommended.

As a potential cause of depression and anxiety was thought to be based around Jinn possession, the treatment is focused on this phenomenon for Mohammad:

> *"I think the imam would pray with the person who is poorly near them…and then the jinn or whatever would leave the person's body that way…and this should make the person then feel better" (Mohammad, P8, 300-302)*

Reaching out to a religious leader, (the imam) is spoken of here rather than a therapist. Imam's are often seen as being full of wisdom, can give advice and are usually seen as being spiritual and religious. As they are seen as being close to God, their prayers are often viewed as being more powerful than other Muslims'. The word poorly could suggest that Mohammad sees the treatment of physical medical problems as being the same as the treatment for mental health problems. The difference here is that physical problems are addressed in this manner but in addition to this, medical intervention is usually also utilised – whereas, in this scenario just seeking help from an imam is mentioned with no reference to a mental health professional. The power of prayer and asking God for help is also implied as the imam would pray to God for assistance.

The idea that the Jinn would leave the body as a result of the imam's prayer sounds like an efficient practice and measurable by the individual's symptoms after this event has occurred. To me, the results from this sound somewhat magical and instant – contrary to the methods used in therapeutic practices which involve long-term work and can be very demanding. It is not understood how Mohammad would define "make the person feel better" – this could refer to their behaviour after the imam has intervened or the psychological symptoms that overlap with that of the possession-based symptoms such as thinking negatively, easily irritable and anxious. Overall, for Mohammad, the help of the imam is seen as being top priority, rather than seeking the assistance of a mental health professional.

Yousuf focuses more on the idea that God should be asked for help:

> *"The difficult things that you are encountering in life, such as your health maybe or a mental health problem, they are all tests to see whether or not you will pass them or fail them – passing them would mean…getting through the struggles whilst remembering God. That's the test- God seeing whether or not you will remember him when you are going through difficult times. People who fail this are those people that forget to ask him for help" (Yousuf, P6, 239-244)*

Yousuf offers the explanation that life is a test from God and the difficulties that we endure, such as mental health problems, are a part of this assessment. The notion that life is a test suggests therefore that there are right and wrong answers too – it is implied that the right answer would be to remember God and consequently the wrong answer or action to problems is neglecting the remembrance of God. Either passing or failing further clarifies that Yousuf is in the belief that there are right or wrong actions. Many different emotions could be engaged from such a belief. This idea may provide hope, as the problems that people are dealing with are from God with the intention of seeing how we would react, which could be reassuring as this implies that they can pass the test by remembering God. However, I imagine that this could also cause some anxiety as individuals who are not getting better from their symptoms may feel as though the test is enduring and that they are not therefore 'passing' the examination correctly. Further to this, the belief that people are failures if they do not ask God for help may also add to feelings of guilt and shame.

Seeking help from an imam or from the remembrance of God are on-going themes throughout the transcripts. In contrast to this, Ibrahim believes that God and Islam would support the idea of therapy as he mentions his desire to talk to a therapist about his car accident, which he believes was the cause of his mental health problems:

> *"I haven't spoken to anyone about mental health problems before…discussing that would be a good place to start…I would want to believe that God wants us to be happy and to do anything that we are doing to make us feel better, as long as it's not going against the faith, would be beneficial and I think supported, by God." (Ibrahim, P2, 48-59)*

His image of therapy not being against the faith (Islam) is the reason why he believes it is okay to seek therapeutic help, so perhaps then there is a tarnished image of therapy for participants who did not mention therapy as being a tool to their recovery of mental health. Perhaps they believe that therapy is something that would be opposing Islamic traditions. Similarly, Shams also supports the idea of therapy:

> *"I think, good on them, I think it's a smart thing to do" (Shams, P11, 379)*

Although he has not sought therapy himself, Shams would support other Muslim men if they were to have therapy, he also acknowledged the benefits of seeking therapeutic intervention. From this, we can see that there were positive and negative opinions towards therapy as well as different possible alternatives to therapy which were influenced heavily from an Islamic perspective.

3.4 Intergenerational conflict and masculinity within Islam.

The focus of this superordinate theme lies in the participants' concepts of what masculinity may be and how this could possibly be shaped by their religious and cultural interpretations. This extends into the perceived expectations of men which then consequently lead into their behavioural outcomes, such as that of secrecy and avoidance. This understudied dynamic aims to address and allow insight into the reluctance of men seeking therapy and identifies their skewed impressions towards mental health and individual responsibility. Further to this, conflicts around differences between first and second generational viewpoints are also explored.

Three Subordinate themes are presented: "**Man is the head of the house**", "**Thinking differently to the first generation**" and "**Men hiding their problems**"

Man is the head of the house.

It became apparent throughout the interviews that the gender constructs that the participants had, heavily influenced their ability or inability to engage with therapy, discuss mental health problems and identify their position within the familial system.

Mohammad explains:

> *"Because I was the eldest I was expected to just get on with it…when my dad died, it was as though there was a gap in a role that needed to be filled…men are supposed to protect women, not that women are weak, but just that that is the role… the earliest memory I have of them saying that to me was when I was about 12 years old…I didn't ask for it but it's there - a silent expectation I'd call it…" (Mohammad, P4, 140-147)*

This implies that men and women have roles within the familial system and that his father was fulfilling a certain role until he passed away. The role was that of the protector of the women within the family. The fact that Mohammad is the eldest and therefore this is his duty reflects the responsibility that usually falls upon the eldest child within Asian and Muslim families as a result of obligational expectations. As Mohammad was expected to just get on with the role, this suggests that these responsibilities are often innate within communities and are familiar as well as consistent throughout the generations.

At other points in the interview, he discusses how he was unable to process the death of his father fully as these duties were overwhelmingly important and resulted in a lack of room or time to properly bereave; this is reflected in his words when he states he did not ask for this role and when Mohammad discusses the age at which he was first introduced to this idea. If there is little to no time for the 'head of the house', to process and deal with his own grievances, then this could suggest that Muslim men are expected to put the needs of other family members above their own, which could lead to detrimental consequences for their mental health. Matters of self-neglect and the position of men are continued with Yousuf:

> *"There's an idea about masculinity in Islam, which is basically that the man is the head of the house, he should be working and earning money for his family… being male means that we cannot open up because that's not what men do…that men aren't supposed to talk about their feelings and that they are weak for doing so. And if a man cried – that is just something unheard of in our culture. I don't think I've ever seen my dad cry…or any Muslim man really" (Yousuf, P7, 308-310)*

Yousuf's thoughts mirror that of Mohammad's. According to Yousuf, the idea that the man is the head of the house is associated with Islam, rather than as a result of their cultural influences. Therefore, even if there are any problems with the man who is the head of the house, he has to continue being able to provide for his family regardless of his personal conflicts. The concept that men cannot open up is from a masculine interpretation rather than a religious influence, according to Yousuf. However, the idea of a man crying being an unimaginable concept is addressed from a cultural stance. Overall, Yousuf addresses the role of masculinity and mental health from a religious, cultural and gender-related view point – suggesting that the influence of the idea that the man is the head of the house is a result of all three of these factors rather than just a religious influence. Musa discusses this further:

> *"Because there's this idea that men need to be strong for the family and be able to keep themselves together, no matter what." (Musa, P6, 203-204)*

Musa's views are quite similar to that of Yousuf and Mohammad's. Although he does not mention men being the head of the house, the idea that the men need to be strong, mirrors the notion that they need to be supportive of the other family members before they attend to their own wellbeing. "Keep themselves together" implies that these men often fall apart, unravel and are emotionally exhausted but continue to appear composed and untouched by emotion in an effort to maintain an image and fulfil the role of looking after their family, unconditionally. If the man is supposed to appear strong, then this strength is shown by burying his feelings, the opposite of which would therefore mean that expressing your feelings is a weakness, an unacceptable commodity for the 'head of the house', for if he is weak, the whole house could crumble.

Whilst these participants discuss the difficulties of being the head of the house and needing to restrain from sharing their mental health problems, Shams discusses how difficult it is being on the opposing end and addressing the patriarch with such problems:

> *"I am going to get through this with consistency. I was determined. And he was angry with me for even bringing it up, like you can't even question your dad, you just can't. So that took about 5 or 6 years to break that wall…he just had too much ego to admit that I was right and he was wrong. Far too much ego…at times I did want him to admit that he was wrong and put his hands up and admit it but then I stopped wanting that, getting the change was enough." (Shams, P9, 318-325)*

Shams highlights how difficult it can be for Muslim men to discuss their issues if the 'head of the house' does not recognise mental health problems. Not being able to question the father and receiving an angry reaction when discussing such matters reflects the difficulty of prompting such a conversation in the first place. It seems it is Shams' determination of wanting his father to understand his problems that motivated him to enable such a

discussion. He recognises how tough it would be to undo years of stigma around the topic of mental health, but believed that with consistency and repetition, he would be able to change his father's viewpoint. Shams' understanding of his father's reluctance to discuss mental health is because of his cultural upbringing rather than religious factors, reflected in his role as the dominant male and the implications this has on the ego and concept of masculinity.

Thinking differently to the first generation.

This subordinate theme examines the participants' dissimilarities between themselves (second generation Muslims) and first generation Muslims and how these discrepancies are predominantly guided by the Western culture that the participants have been born and raised into as opposed to the traditions of the first generation of Muslims who in this study are from India, Pakistan, Bangladesh and Saudi Arabia. Participant two stated:

> *"I'm grateful for the dual culture of being Asian but also British because this means I found it easier to see the point of view of experts (GP)." (Adam, P3, 85-87)*

Adam believes that when he received his diagnosis of anxiety, his upbringing in Britain contributed towards a better understanding and acceptance of his diagnosis from the GP, if he were to compare it to first generation Muslims who he perceives as not accepting their mental health problems. This could further imply that Adam is conscious of the influences from both cultures and from both of these backgrounds in terms of his impressions of mental health. Rashid has similar views:

> *"I don't think I've ever met a Muslim who wasn't born in the UK who thought it was okay to ask for help from a therapist" (Rashid, P7, 232-233)*

Rashid also believes that first generation Muslim men think differently to the second generation. He believes that his parent's cultural influence of being born in Bangladesh has resulted in them being unable to accept support from a therapist. This participant does not mention religion being the influential factor between the generations, but rather the cultural disposition. It could be assumed that these differences, such as the views of therapeutic intervention and even the recognition of mental health problems, could be causing friction between the participants and their parents/family members who do not understand or relate to mental health problems like they do. This lack of understanding might contribute towards the participant's reluctance to communicate their feelings around their depression and anxiety to their loved ones and to seek therapy.

> *"I don't think I'm shaped by it (culture) as much as the generation of Muslims that were born back home in Asia" (Mohammad, P2, 71-73)*

Mohammad believes that his Asian culture has tried to impact his views on mental health but he has not been as heavily persuaded by it as much as first generation Asians. This further adds to the notion that the generations see mental health differently. It appears that second generation Muslim men are more open to the concepts of

mental health and are more likely to seek therapy, whereas the first generation are described as rejecting the idea of mental health problems and therapy – and hypothetically so as a result of their cultural upbringing. This would then also suggest that there is as an aspect of British or Western culture that encourages or doesn't add barriers to Muslim men seeking help, when compared to Asian and Arab cultures.

> *"I don't personally see how it (believing in mental health problems) could clash with my faith. If I believe in mental health problems then that doesn't mean that I'm any less religious or any less of a Muslim than someone who doesn't believe in it." (Yousuf, P2, 60-62)*

Yousuf also compares his beliefs to that of the first generation. He is protective of his stance towards mental health and religious beliefs. It almost sounds as though he is defending his religiosity by stating there are no clashes between Islam and mental health problems. This makes me wonder if he has to defend his beliefs quite regularly as he appeared to be almost re-enacting a scenario during the interview which appeared as though he was sharing his views in a manner that appeared rehearsed or familiar to him. Perhaps these debates where he has to guard his opinions from others are regular and provoked by those of the first generation, who as he states do not understand mental health problems. Such scenarios could create hostility towards community members, generations and could possibly lead to internal conflict and guilt for Yousuf who is being accused of lacking religiosity as a result of his coherent understanding of mental health problems.

> *"Men aren't supposed to talk about their feelings – it's horrible and if I ever had sons I would encourage them to talk to me about what they are feeling, but I think it's too late for my generation, from what I've seen anyway. Maybe it's too late to change our way of thinking because there have been a lot of years of making us think the way we do – that men aren't supposed to talk about their feelings and that they are weak for doing so." (Yousuf, P3, 105-109)*

Yousuf further goes on to describe the generational differences in terms of the third generation. He would raise his own son differently implies that he identifies the problems within his own upbringing in relation to his culture and the views of mental health that he was raised with. Encouraging his son in particular implies that he has also understood that there are taboos around men in particular in discussing their feelings and ideas of masculinity – that speaking about feelings is linked to weaknesses. This statement from Yousuf provides both hope and discouragement. The discouragement lies within the belief that it is too late for the current second generation of Muslims to recognise mental health as being a necessary component of life and their consequential inability to therefore seek help and treatment. Yet there is hope that future generations will be educated about the importance of discussing mental health, emotions and thoughts expressively, disentangling the views of masculinity and therefore hope of mental health being acknowledged and spoken of in Muslim communities.

However, Shams identifies the differences between himself and his father, yet encouraged himself to address his emotions with him:

> *"I spoke to him about being overly aggressive towards me, I was 22 and I just blew up and all the anger inside me just came out. He obviously didn't respond to that very well… I kept bringing up situations like why did you reduce me to tears over these small things? And being a Pakistani, he was first like who do*

> *you think you are telling me this? It was a tough barrier that I first had to break through" (Shams, P9, 305-315)*

Despite knowing that it would take him a while to convey his feelings to his father who was born and raised in Pakistan, he knew he had to attempt to discuss the matter of his mental health with him as he believed his main problems of anxiety and anger stemmed from his parental upbringing. Shams also suggests that Pakistani Muslim fathers may be difficult to have a discussion with in regards to matters of emotions and especially concerning situations in which their parenting could be questioned. However, the personal offence taken when their parenting is criticised does not seem to stem from a belief that they feel vulnerable, but rather that their authority as the patriarch cannot be questioned, which Shams believes is a result of their Pakistani culture rather than the influence of Islamic teachings. Shams accepts and challenges the differences between first and second generational viewpoints in an attempt to deal with his own problems but also to make changes within the community that would ideally lead to more open discussions of mental health problems.

Men hiding their problems.

A common theme amongst the participants was that of men concealing their thoughts and even behaviours around mental health which may be seen as unordinary or differing from that of their community or family members.

Musa explains:

> *"I think I actually do want to go for therapy…but, I'd have to keep it a secret." (Musa, P6, 202-203)*

The word 'secret' suggests something unspoken about, taboo or restricted. There is an element of risk when secrets are not hidden – this potential possibility could be a reason why Musa has avoided therapy for so long. The likelihood that someone from within the community would find out about their treatment could have a lasting impact on the impression of the client from others. Musa stated wanting to go to therapy as though it were almost an epiphany. He appeared shocked at his own statement, as reflected in his appearance during the interview. It is apparent that this may have been the first time that Musa decided that he wants to seek therapy. Which means that the idea of keeping therapy a secret was the initial thought he had after deciding to ask for treatment; this suggests that Musa's need for secrecy around this matter is almost instinctive if hiding therapy is his first thought. Rather than associating therapy with positive factors such as that of support, personal development and care, he instead immediately associated it with the negatives, such as that of the thoughts of others and the way in which to maintain secrecy from others.

Adam reflects similar thoughts:

> *"Because it gives the idea that maybe I am vulnerable or weak by talking about this stuff. Because women talk about it a lot, it is like we associate it with being something that only women do. So it would be really girly or feminine of me to open up and talk about how I'm feeling, if that makes sense. I know*

> *that sounds stupid but that is honestly how I think I and other men would be portrayed or how we would feel if we were to open up" (Adam, P7, 251-256)*

Here, Adam discusses choosing not to reveal his inner thoughts and feelings and somewhat keeping them hidden from others. Whilst Musa is afraid that his secrecy will reveal his engagement with therapy, Adam seems to be concerned with his image of being manly being upheld, resulting in him not divulging his problems or seeking therapy. It appears that hiding their problems is more important than being open, vulnerable and challenging the stigma around therapy within the community. Perhaps the idea of disclosing something in regards to their mental health is seen as being far more catastrophic than the actual reality of the repercussions. The participants seem to display behaviours of avoidance when challenged with the concept of discussing their mental health problems. In some regards, Adam calls his actions 'stupid', suggesting he is aware of the limitations that his behaviour is presenting, but nonetheless he continues as hiding his feelings is more normal than talking about his problems – and the consequences of discussing his actions are too problematic.

> *"I still react how most Muslim men would, by not discussing it with our families" (Musa, P3, 83-84)*

Musa speaks about specifically not discussing his problems with his family, rather than talking about the community or his concept of vulnerability. Therefore, another factor that could contribute towards the participants' lack of motivation to share their problems is the likelihood of family members understanding their concerns. He would rather keep the problems a secret than share them - the fact that he states most Muslim men would react this way suggests that this behaviour is normalised amongst the community with aspects of conformity.

> *"These men who feel that anything that's inside them, that doesn't feel right, whether its anxiety or whatever, they shouldn't talk about it, you should just do what you've been told growing up and you get on with life and you get on with things. And that's what I mean by subservient attitude" (Shams, P4, 109-112)*

Shams explains how Muslim men reach this state of burying their feelings as a result of their cultural upbringing, rather than religious factors. Their secretive nature is suggested to be linked with a subservient attitude – this paints a slightly different picture of Muslim men in the sense that being subservient implies passivity, yet it still parallels earlier thoughts from other participants around Muslim men being dutiful of their obligations and remaining silent regardless of their internal struggles.

> *"I'm aware of the way men can often behave, in terms of not wanting to share their feelings and being emotionally withdrawn" (Rashid, P5, 113-114)*

However, Rashid challenges the stereotypes that he sees within the community. He admits openly talking about his depression with women he's dated and anyone else that asks him about his problems in an attempt to fight the stereotype that men withhold their emotions. Although Rashid is able to openly discuss his problems with his friends and partner, he further explains:

> *"I openly talk about them…not to my imam father though or to my mum because that's different – it's not as if I'm hiding it from them because I'm a man and I have to be strong! No, I simply don't tell them*

> *because they would not understand so what is the point…I think they would just criticise" (Rashid, P3, 88-92)*

He still finds it difficult to share his thoughts about mental health with his parents. In particular, he mentions it being difficult to talk about his anxiety with his father who is an imam. He defends his reasoning to withhold information from his parents and implies that he chooses to do so based on their lack of acceptance rather than his views on masculinity and what men should and should not disclose. For Rashid, he finds it important to challenge views about masculinity around men having to be 'strong', but is reluctant to share his mental health problems when he feels as though the other person will not accept or understand his viewpoint. Whereas Shams actively engages in discussions with his family members around mental health, in an attempt to change their perspective and address the stigma associated within Asian communities.

Chapter Four

Discussion

This chapter investigates the findings in relation to existing literature, and deliberates the suggestions of this for clinical practice. It then inspects the limitations of the current research and proposes directions for further research. The final segment of this chapter provides a reflexive statement deliberating the researcher's personal thoughts and reflections on the research.

4.1 Summary of results

The current study aimed to explore Muslim men's experiences of mental health problems and how these experiences could possibly be influenced by their religious beliefs. The analysis identified three superordinate themes: "**Perceived stigma from community**", "**Mental health issues as seen from an Islamic perspective"** and "**Intergenerational conflict and masculinity within Islam**". The main findings from this research are that Muslim men often experience their mental health problems from within the realm of secrecy, there are areas of intergenerational conflict between Muslim men and their families, influenced heavily from the views of masculinity and that there are positions of scepticism around therapy and the aetiology of disorders based on beliefs around the effects of supernatural beings (Jinn and the devil). The participants expressed their difficulties with managing stigma from within their cultural communities, the problems with accessing therapy, the notion that there might be an aspect of neglect to religious duties towards God that contributes towards mental health problems and issues around masculinity and men needing to look after their families and put the needs of others above their own.

4.2 Research findings in relation to the existing literature and the implications of these findings

This section will discuss the findings from this research along with existing literature and the proposed effects of these on clinical practice. This study is the first of its kind in terms of looking into the first-hand views and experiences of Muslim men and their mental health problems. Prior to this, research focused on providing adapted psychological interventions for Muslim clients and the experiences of Muslim women around their mental health, leaving the discussion around Muslim men fairly scarce.

The current findings have helped gain an understanding into the inner-workings and lives of Muslim men dealing with their mental health problems, their beliefs around mental health issues, and the hindrances they face when trying to access therapy and the relation to all of this within their faith and culture. In particular, themes around masculinity, intergenerational differences and influences from supernatural beings have been identified as significant and the first of their kind in relation to this demographic.

4.3 First Superordinate theme: Perceived stigma from community:

The findings from this research showed that all participants experienced a sense of shame associated with the stigma related to psychological and mental health problems. The fear mainly orientating around disgracing their family and degrading their image within the community if their problems were disclosed. This finding is parallel to that of Bowl's (2007) in which the research discusses how stigma negatively affects the ability of South Asian Muslims disclosing their problems – also including Muslim men. This study highlighted how mental health problems are seen as being personal familial matters and the discussion of such topics outside this group can cause the individual and their family members to be seen differently amongst the community. This study revealed how the participants saw the discussion of mental health or psychological problems as being taboo and highly unorthodox – the Muslim men felt as though they are degrading their family and image amongst the community, which in a collectivist culture is of significant importance; this finding mirrored that of Seegobin (1999) in which South Asian men experienced shame around help seeking behaviours.

The finding mentioned above has been shown in other research, however the first superordinate theme also reveals a new finding of how stigma-related labels given to individual family members can be generalised to reflect the entire family. Participants described others who openly discussed their mental health problems as being labelled as "crazy" or "mental". Some of the participants even mentioned that these labels could then become a representation of the entire family to which the person with a mental health problem belongs, with terms such as "the mental family" or "family with the insane person" being utilised. Therefore, in a bid to save themselves and their families from what they described as "humiliation", none of the participants disclosed their mental health problems to other Muslims or Asians from within their close communities. Another important finding from this study was that six out of the seven participants confessed that they would like to seek therapy but were reluctant to do so because of the perceived stigma from the members of the Muslim community. Perceived stigma has been seen to minimise the possibility that Muslim men will seek therapeutic help in past research (Tarabi *et al*, 2018).

Another important finding was that even though many of the participants tried, they were hesitant to even disclose their mental health problems to their family and friends. This was because the parents, siblings or partners of the participants would immediately be overly concerned with how the Muslim men's mental health problems would portray the family in a negative light, rather than being concerned about the wellbeing of the Muslim men. Similar findings can be identified in Ciftci (2012) where Muslims' were reluctant to seek therapy because of societal pressures; however, little was mentioned about Muslim men in this regard. In this research, men were discouraged by family members to seek therapy and were instead diverted towards religious practices such as prayer and fasting to tackle the mental health problem. It is important to note that from this study, it became apparent that the family members of all seven participants did not acknowledge or agree with the participants' mental health diagnosis given by the participants' GP's. This was because the label of mental health difficulties, if discovered by others, would yield shame for the individual and their families amongst the community.

It is also significant to note that because the families were reluctant to accept the mental health problem, they then discouraged the participants from seeking therapeutic help by saying "therapy can't help". This is also in an

attempt to shield and protect the family image, as seeking help from an external source is almost seen as an act of betrayal. And since the diagnosis' are not accepted, it is therefore understandable why the families of the participants would be unsupportive in them seeking therapy (Haque 2001). Little research has been previously undertaken with the focus on the effects of a mental health diagnosis on Muslim men and their families, therefore this research is unique in identifying the systemic dynamics that mental health can create. In particular, the rejection of the diagnosis from the Muslim men's family members and friends is of key significance.

The participants however were accepting of their mental health diagnosis given by their GP's. They discussed how their visits to their doctors were either due to problems with sleep, poor appetite or panic attacks (with the belief that they were experiencing heart problems). This highlighted that the participants were primarily unaware that their own difficulties could be classified as mental health problems and rather they sought help from their GP's as they were concerned about their physical health problems. This is because physical health problems are seen as being less controversial than mental health problems. After their diagnosis', participants felt a sense of confusion and denial as they were aware of the implications that this would have on the family's status and identity amongst the community. According to Cifti (2012), Asians tend to describe mental health problems in the form of physical health symptoms as there are fewer stigmas around physical health.

The current study suggested that men from South Asian communities perceive stigma from within their communities which may result in a reluctance to seek therapeutic help and engage in open dialogues with loved ones around their psychological wellbeing, this is also reflected in studies by that of Addis *et al,* (2003). However, a new finding from this research is that whilst the participants did reveal an interest in engaging with therapy, they stated that they would only do so as a final step and if all other options yielded no positive outcomes for the participants. But even then, the participants stated that they would not reveal their attendance of therapy with their community or family members due to the fear of stigma and judgement.

Interestingly, the shame and guilt discussed within this theme is mainly based around cultural expectations rather than ties with Islam or the Muslim faith. At this stage, participants were not necessarily discussing stigma that resulted in being derived from religious expectations but rather that of cultural obligations. This suggests that cultural influences are heavily instrumental in this group of clients potentially seeking therapy, and the stigma is innate from within the communities and is somewhat also influenced by religious implications at times. Studies have not necessarily looked at religion and culture together before and have instead focused primarily on south Asians as a whole (Cifti 2012). This is the first study of its kind, to the knowledge of the researcher, which has looked directly as Muslim men's experiences of mental health problems and therefore taken into account both the religious and cultural attitudes of the participants.

Remarkably, and not previously discussed in studies, the Muslim men in this research were conscious of the stigma from family members and communities and even though they did not actively challenge them, they appeared to be frustrated, "it's annoying that this is the way it is in Asian and Muslim communities", this suggests that perhaps more awareness is taking place amongst Muslim men, even though the opinions of the community are still impacting their decisions to speak out about mental health problems. Cifti (2012) found that the differences between first generation immigrants and their second generation children were significant when it came to views on health overall, but mental health was not specifically examined.

The stigmatic phenomena discussed in this superordinate theme links into the second superordinate theme which is that of mental health issues being seen from an Islamic perspective. From the data gathered in this research, the stigma around mental health problems being a taboo subject of discussion amongst Muslim communities influences and is influenced by the way mental health issues are viewed. The participants discussed how the stigma revolved around mental health being seen as a deviation from religious practices or lack of prayer leads to the suggestion that the men "betrayed God" and should seek help from imams and recitation of the holy scriptures. There was a key link between the perception of mental health leading to the stigma and then influencing how the mental health problems were addressed.

4.4 Second Superordinate theme: Mental health issues as seen from an Islamic perspective:

One of the aims of this research was to explore how and if the religious views of Muslim men impact their views of mental health and how they interact with their experiences of mental health problems. Past studies have shown how Muslim men experience guilt around mental health problems sue to stigma from external individuals. A new finding from this study was that the Muslim men also felt guilty as they thought they were betraying God and blamed themselves for any of their mental health problems due to a lack of connection with God. This opinion seems to originate from the first generation, religious and cultural influences. Similar to this, a study by Ahmed (2013) found that South Asian men found it more appropriate to seek help from God rather than asking others for help, but this did not look specifically at Muslim men. This study found that the participants felt as though not only would others think they are 'bad' Muslims for not seeking help from God alone, but that they were sabotaging their religious connection with God by doing so.

No past studies, to the knowledge of the researcher, have asked second generation Muslim men what they think the aetiology and treatment options of mental health problems might be. Much like their dual culture and dual identities, the participants in this study seemed to also have dual theories for how and why mental health problems form. One of the findings was that the participants approached this topic from a religious and cultural influential perspective and discussed the lack of closeness to God, lack of prayer, not remembering God and neglecting their faith as being the primary reason for psychological problems. In contrast to this, they also suggested that lifestyle, biological, environmental and significant life events as well as upbringing contributed towards mental health (Ahmed, 2013).

It seems the participants' bicultural upbringing and religious practice has caused them to adopt sets of ideals, one heavily influenced from the Western perspective and the other largely influenced by their Eastern values and Islamic teachings. When asked about their faith and the aetiology of disorders, many of the participants would quote the Quran with verses such as "With the remembrance of God do hearts find rest" and "seek help through patience and prayer." Amri (2012) found that American Muslim immigrants preferred to seek help from God rather than therapeutic services, but this study looks at second generation men in the UK. Not only do these verses suggest ways in which Muslims could potentially address their mental health problems, but they were also interpreted by the participants as being reasons why the mental health problems would exist in the first place. As the Quran and these verses are studied from a young age, it is reasonable to expect the participants to relate to these passages when discussing anything about life or health. However, the participants were also able

to identify the role of their Western upbringing in allowing them to recognise that the causes of mental health problems might be related to life events.

Another new finding from this study with Muslim men is that the participants spoke quite in depth about mental health problems being potentially caused by Jinn (beings created from a smokeless fire, able to possess humans). They referenced the Quran when discussing them as possible reasons for psychological problems. Interestingly, there are little to no studies that discuss this previously from a participant-perspective. Muslim women have however discusses similar beliefs according to Cifti (2012). However, past research is limited to Muslim men stating that jinn possession could be the cause of mental health problems. Interestingly, they discussed the symptoms of the possession being similar to that of depression – problems sleeping, low appetite, low mood, irritability and isolation.

A new finding from this research is that what the participants viewed as possible treatment ideas were heavily influenced by what the participants believed the causes and understanding of their problems to be; if they believed the problems to be in relation to their mental health, then they were more likely to seek therapeutic help, but if they saw their difficulties as being caused by poor connection with God or jinn possession, they were more likely to seek the appropriate treatment option as being prayer, seeing an imam or other religious-based suggestions, rather than therapy. This is not to say that religion has no space in the treatment of mental health difficulties, in fact research shows that religion can play an important part in the recovery of psychological difficulties according to Utz (2011); however this does highlight how the possibility of both religious techniques and therapeutic input are disregarded.

One of the purposes of this research was to explore actual conceptions of mental illness within this population, since previous research primarily focused on ways in which therapy can be adapted for Muslims. Culturally or religiously based differences in conceptualizations of mental illness can completely alter the approach of individuals toward psychological problems, and affect their perceptions of the best ways to handle dysfunction and distressful conditions. Islamic perspectives on psychopathology, and traditional conceptions of mental illness within the context of Muslim societies, often differ from conceptions of mental illness outlined by the Western mental health system in the United Kingdom, as well as from mainstream British conceptualizations of mental illness in the general lay population. This lack of an analogous definition of mental illness in the two cultural contexts, or equivalent predictors of mental illness may be a corresponding factor in the underutilization of mental health services by British Muslims.

4.5 Third Superordinate theme: Intergenerational conflict and masculinity within Islam:

An important finding from this study was that participants disclosed that a reason for their disengagement from therapy services might be because it is a threat to their masculine identity. Similar findings were discovered by Tarabi *et al* (2018) in which Pakistani Muslim men discussed how their masculine identity inhibits them from seeking therapy. This is also parallel to other research that suggests South Asian men are less likely to seek therapy than any other demographic of men in the UK (Ahmed & Amer, 2012).

Many of the participants indicated being the 'head of the house' if their father was not present. This often signified a heightened sense of responsibility towards other family members, in particular those who are female. It was suggested that this is not because women cannot look after themselves, but rather that it was the 'duty' of the man to provide for them financially and support them emotionally. These findings are also mirrored by Cifti (2012), in which Pakistani men reported feeling as though they had to take care of their families. However, this research highlights a new finding of how the participants saw that once this responsibility falls on the Muslim man, he is then somewhat unable to focus on himself and his own worries – this includes mental health problems. Interestingly enough, physical health problems were allowed to be addressed.

Many of the participants cited this sense of responsibility as a religious and cultural obligation. The participants felt as though the Quran suggested that they should look after their family members. However, the implication that this means that they can therefore not look after themselves stems from cultural expectations of what a man should do and what his duties as the head of the house might be. Similar to the above findings, Bhui *et al* (2002) state that South Asian men do not seek therapeutic help or recognise their own psychological problems because this could negatively impact their perceived gender obligations of being resilient, reliable and disciplined. If they sought help for themselves, they would be neglecting their religious and cultural duties.

According to Seidler, Rice, Dhillon and Herrman (2019), masculinity mediates health outcomes by influencing engagement with treatment as well as help seeking behaviours; thus, suggesting that men's expressions of masculinity are relevant to their mental health status. Such research is parallel to this current study that shows that Muslim men seek answers and adopt ideas of what masculinity is from their faith. This is not to say that religion is the only source that constructs Muslim men's masculinity, but that the Muslim men viewed the Quranic verses addressing gender roles and the responsibility of men as being a key factor in forming their idea of themselves along with their masculinity. The men adopted a role as "head of the house" as a result of the guidance offered by religious texts. These roles established the Muslim men as needing to be "strong", "providers" and "protectors" of their families; the participants suggested that these roles appointed to them were one of the reasons why they could not be transparent with loved ones when they experienced mental health problems. The role of being the head of the house meant that they had a duty to carry out which almost prohibits them from addressing their own issues, as they have other "duties" to attend to. Certainly it could be said that such ideas transpire across many religions and cultures (Seidler *et al*, 2019) however, these participants identify these ideas as being sourced from their religious interpretations. Similarly, Conrad and Warwick-Booth (2010) argue that a large proportion of men are trapped in traditional masculine identities which can be detrimental in allowing them to seek help for their mental health. Level of acculturation is also viewed as a possible factor in the underutilization of mental health services (Seidler *et al*, 2019). First and second generation individuals with close ties to traditional Muslim cultures, often lead to the rejection of the utilization of sources outside of the family for assistance in mental health issues (Conrad *et al* 2010).

Such roles and concepts of masculinity, when derived partly from religious meanings, can then impact on other areas of the participants' lives. There is an intertwining affect of masculinity concepts in relation to the first superordinate theme of perceived stigma. It became apparent during the interviews that the beliefs around what men should be and do then transpired into stigmatic notions if the men did not meet the expectations set for them by the communities, which are based on religious and cultural influence. Furthermore, this also ties in with

the second superordinate theme of mental health problems often being seen as a deviation from faith; when the men are unable to carry out their "duties", this is seen as a potential "betrayal" to the laws of God, which is used to explain the symptoms of mental health problems – this then leads to the subtheme of "alternatives to therapy in Islam" becoming relevant as methods such as prayer and devotion to God are sought in order to make "amends" and alleviate symptoms of mental health problems.

Another noteworthy finding from this study was the generational differences and how these impacted the participants' psychological wellbeing and decision making processes. As well as recognising that the views on masculinity might be influenced by religion and culture, the participants shared the idea that this role was one that originates from generational influence as well. Generational differences and the distress that this caused participants were highly prevalent throughout all seven interviews. Adhering to the rules and regulations set by the first generation caused the participants a great deal of struggle but ultimately they would comply with the expectations from their parents and community members from the first generation. The participants stated that this was because the elders are supposed to be respected and listened to but also this might be because the first generation has found it difficult to assimilate and therefore are unsure of how to allow the second generation to deviate from their expected duties, as also found by Bowl, (2007).

A significant and new outcome was found in how the participants reported being "torn" between both their western and Eastern cultures. They felt a divide between themselves and the first generation when it came to aspects of cultural and religious obligations but also when it came to views on mental health. Some of the participants even blamed their parents and the first generation of not being active enough in trying to adapt to the western society or being reluctant in teaching the second generation about mental health. It could therefore be argued to some extent that Muslim men feel pressured into becoming the head of the house because their families do not understand the difficulties that they have with managing both cultural values simultaneously, as discussed also by Tarabi *et al*, (2018).

This research also found that the participants felt as though they had a specific identity when around their family in which they have to abide by the cultural expectations as well as the religious expectations imposed up on them. Whereas the other identity takes shape outside the familial home and in an attempt to help meet the cultural expectations of Western, UK culture. The participants expressed feeling stuck in the middle with two opposing identities or personalities. Similar to the above findings, Lalonde & Giguère, (2008) explored the difficulties and concerns of second generation individuals regarding the cultural clashes that arise from the incompatibility of the expectations from both sets of cultures. Lalonde & Giguère, (2008) discussed how these opposing expectations may stem from the structural nature of each individual culture. The Western culture is largely that of an individualistic nature which encourages autonomy, self-focus, personal growth and development as well as independence. Whereas traditional Eastern cultures and certainly even aspects of the Islamic faith encourage the collectivist format where individuals are an aspect of a larger group and there is a strong focus on community interdependence and familial connectedness which then leads to encouraging individuals to align themselves with values that are recognised by the community (Tarabi *et al*, 2018).

This research also showed that participants felt as though they struggled with choosing one identity or set of values over another, which often left them feeling alone and misunderstood. However, they were reluctant to abandon one set of rules over another in the fear that they might be shunned from their communities or familial relationships. This has been somewhat highlighted previously in a study by Cifti (2012), but this study in particular found that participants said it was difficult to accept neglecting their obligations stemming from a religious influence rather than cultural. The participants seemed more likely to occasionally challenge cultural expectations than religious ones. When explored further, this was because religious expectations held more value for the participants and going against this notion was almost seen as an act of betrayal to God, and to themselves.

As this is the first study to look at the subjective views of second generation Muslim men and their mental health, the Muslim men had opportunities to discuss their experiences in a manner in which was not previously explored. Therefore this generated a new finding about the ways in which Muslim men approach their parents about differing opinions on mental health problems. Only one of the participants spoke about challenging the expectations and traditions passed down from the first generation. But even he addressed how difficult this was and how it took him years to break down barriers with father. From this, it became apparent that if first generation men are the head of the house, then challenging them as a second generation Muslim male can be daunting and requires a lot of determination. The resistance to change displayed by the first generation, as described by the participants, is in direct relation to their fear of losing their cultural and religious traditions (Cifti 2012). These anxieties and attempts to grasp on to traditional values and obligations is passed directly on to the second generation Muslim men who find it difficult to reject their father's given responsibilities and rules. Fedele (2013) also explored how Muslim male immigrants may find it challenging to grasp the concept of mental health problems but did not look into how this can impact the second generation. This study shows that often, the differing views can lead to clashes within the home if there is resistance from the second generation. According to the participants, the main difference between the first and second generation being able to be more accepting of mental health awareness might be because the second generation were born in the UK and have a British upbringing and influence.

As the Muslim men discussed their difficulties with their masculine identities as well as the role their parents have on their identities, the present research also identified possible coping strategies that individuals utilise (Sneed *et al* 2003). According to Jaspal *et al* (2012) a commendable component of IPT is its identification of various coping strategies of individuals who perceive a threat to their identity; the individual's choice of coping strategy may differ according to the level of human interdependence. From the present research, it was found that the participants used interpersonal strategies in which the aim was to change the relationship with others. This was carried out by the participants to avoid stigma through isolation from others and some participants were able to self-disclose and share their problems with others whom they trust. None of the participants discussed intergroup strategies which would have involved the participants creating or joining a social group to derive support or encourage change. Intrapsychic strategies were also carried out by the participants when they experienced an identity threat; they deflected, were in denial, and cognitive restructuring took place in anticipation of a threat.

Jaspal *et al* (2012) suggest that British Asians are more susceptible to identity threat than other populations. The present study also indicates that some, particularly the second generation, often felt excluded themselves from the category of being 'British' because their traditional south Asian values might be seen as being contradictory to that of the White British majority. Perhaps the Muslim men along with the first generation parents also felt a threat to the belonging principle of identity due to the reported rise in Islamophobic prejudices. Furthermore, the second generation Muslim men in this study often displayed identity accommodation where they changed their identity in response to experiences. Sneed *et al (*2003), argues that when used in excess, identity accommodation can influence and shape individuals by new experiences because their own sense of identities are incoherent or unstable; this can lead to low self esteem and self doubt through a lack of internal consistency. Furthermore, the participants looked outside of themselves for inner guidance, were likely to evaluate themselves negatively when failing to gain the approval of others and were experiencing highly negative evaluations of their thoughts, feelings, and behaviours because other people's negative evaluations mirrored their own inner confusion and uncertainty (Sneed *et al* 2003).

This present study found that Muslims who demonstrated a strong religious commitment and religious identity often interpreted aspects of their daily lives by using religious language. Participants who predominately adhered to social and cultural norms other than those that were perhaps seen as traditionally British, due to influence from their parents, were more likely to be influenced by these norms in their attitudes, beliefs, and practices. Estimating the level of acculturation of individuals within a population, and determining if this level correlates with specific beliefs and behaviours is important in addressing the problem of the underutilization of mental health services. In addition, religiosity or religious commitment is influential in attitude formation and behaviour. Religious commitment is viewed as an important aspect of maintaining a Muslim identity, and is an acknowledged factor in the formation of values, opinions, and decision-making (Sneed *et al* 2003).

A relevant finding from this study was that participants disclosed wanting to seek therapy, but stated that this would be a secret endeavour. They appeared to be worried about their masculine identity being tarnished if others found out that they were asking for help. This coincides with the fear that they want to appear strong and able to self-manage any difficulties and face any obstacles otherwise they are failing their sense of duty towards other family members. Many of the participants spoke about financial problems too when seeking therapeutic help and how their responsibility towards being the "breadwinner" means they cannot afford to spend money on therapy for themselves as this would be seen as a waste of funds, that this money could be used towards the family. Masculine identity has rarely been researched with Muslim men, studies showing masculinity with men in general show how male constructs can have an impact on their identities which leads to lack of help seeking behaviour for therapy (Erdem, Wilson, Limbrick, and Swainston, 2019). This study found that the participants would be hesitant to disclose their attendance of therapy or anything related to mental health, resulting in secrecy. From a clinical perspective, this suggests that Muslim men might have a lot of secrets from their loved ones, they might be used to hiding their problems and might find it difficult to openly discuss their issues during therapy as they are resistant to do so in their personal lives because of cultural and religious objectives. Therefore, clarification needs to be implemented early in the therapeutic setting for a need to invite Muslim men into an open dialogue about their problems – advocating for such openness might be a new stance for this group,

but inviting them to do so allows the opportunity to include these individuals which mirrors the principles of counselling psychology.

4.6 Summary of findings

Although previous research has not been conducted with second generation Muslim men in which they are directly asked to discuss their subjective experiences of mental health, there are some findings that have been discovered previously in research, such as the stigma of mental health within South Asian and Muslim communities and the secretive nature of men not disclosing their mental health problems with close relatives and friends.

As mentioned, the study is the first piece of research directly asking Muslim men about their mental health and how this links with Islam, there have been some new findings that have not been identified in past literature and studies. One of these findings is the paramount differences between first and second generation Muslim men and how this influences the second generation's ability to seek therapeutic help or acknowledge that they might have difficulties with their mental health. According to the participants, these differences were largely due to differences in upbringing, with the participant's parents being raised in an environment in which mental health was not being discussed, which somewhat contradicts the upbringing of the participants in the UK.

Another new finding was the Muslim men's views on jinn possession being the aetiology of mental health problems. This idea was heavily influenced by the participant's religious beliefs as they quoted verses from the Quran. The study also highlighted that what the participants understood the cause of the mental health problems to be or how they viewed mental health difficulties, influenced the participants' beliefs around what the treatment of their problems could be. Participants that believed in the effects of black magic also believed that an imam or religious healing (reading holy scriptures) would be more beneficial in tackling the problem than psychological therapies. Whereas the participants who viewed the possible causes of mental health concerns as being the result of their environment, upbringing or life events were more likely to seek therapeutic help.

Furthermore, a new finding from this study is that the Muslim men specifically discussed their formulation of masculinity as having derived from their interpretations of religious texts. This construct of masculinity then led to thoughts around obligations to be strong, the head of the house and carer for the family which inevitably means that the participants were unable to attend to their own health needs. Previous research talks about men being strong but in this study, there is an explicit link to religion through quoting of verses from the Quran.

4.7 Clinical applications of research:

Having an insight into the ways in which Muslim men think about mental health problems developing and how they could possibly be treated is a great advantage for therapists who can use these theories to assist and guide

the therapeutic work. For example, consciously opening the discussion about how the individual thinks their faith might be able to help them and how this could work alongside therapeutic interventions would help the clients to feel as though their faith is being considered important and can be compatible with psychological interventions.

As the men were more likely to discuss mental health problems from within the realms of physical problems, they all visited their GP's initially. Therefore, as GP's are most likely the first healthcare worker who might be visited by Muslim men, it is important that they discuss mental health and therapy in more detail with this client group. Mental health problems could be normalised by discussing the amount of people with mental health problems, and that many people from similar religious or ethnic backgrounds as the patients also endure mental health issues. GP's could also discuss how therapists can be knowledgeable about religion, and if they aren't, most are willing to learn and attempt to understand.

From this research, it can be established that GP's and imams could open the discussion about mental health problems from the context of physiological symptoms. They could discuss the physical side effects of depression and anxiety first by providing psychoeducation around increased heart rate, shortness of breath, lack of energy, tiredness, sweatiness and other physical reactions that might accompany mental health problems in general. By doing this, the GP and imams would open a discussion without the Muslim men becoming defensive as physical health is openly discussed, and then the professionals could slowly introduce the idea of anxiety or depression. Furthermore, this study found that semantics played an important role in determining whether or not the participants' parents were willing to engage in discussions around mental health. The term "mental" might be considered "crazy" or associated with stigma, therefore other phrases such as "brain health" or "thinking" or "feeling" might be more culturally appropriate.

Approaching these topics with sensitivity to the semantics and primarily focusing on the consequences of physical health could be a way to engage this demographic; therapists could also use this approach to build and enhance a therapeutic relationship with Muslim male patients. Furthermore, the research suggested that there was a slight hesitancy with asking for therapeutic help as some of the participants and their families believed that seeking therapeutic support might be a deviation from their religious faith. Therefore, therapists have a role to play in clarifying that therapy is not a predominant and singular phenomenon that does not coincide with other approaches, but rather that therapy is an additional resource to the participant's religious practices that they might deem important or helpful in their treatment; the belief that therapy can coincide along with religious or cultural practices without impeding on one's obligations, is an important viewpoint for Muslim men to be aware of. When conducting treatment plans, therapists could incorporate goals that are psychologically appropriate and religiously applicable; this could help Muslim men recognise therapy as another approach that can be implemented alongside their practices of faith.

The lack of knowledge about mental health in the Muslim and Asian communities highlights how counselling psychologist could visit such communities and perhaps even mosques to spread the awareness of mental health and discuss symptoms of mental health problems, so that if anyone is experiencing them, they know that it might not be a physical health problem. The counselling psychologists could also discuss therapy and how their faith can also be discussed during the therapy in an attempt to respect their beliefs and concerns and discuss how

both religion and therapy can work together to help support individuals. Knowledge of how the teachings of the Quran encourage us to seek help and acknowledge mental health problems could also be discussed with imams who are often another source for Muslim men to approach. By equipping imams with knowledge and information about what Muslim men can do to access help within their communities, normalisation of mental health problems could begin to develop and perhaps even open discussions about mental health in general would take place.

More education could be given around mental health at schools and how to recognise mental health problems, the role of psychologists and how mental health is just as important as physical health. Speaking in schools about the topic of masculinity and challenging stereotypes – this is important for Muslim boys who might not be hearing about mental health or masculinity from within their own families or friendship groups.

An overlap between mental health symptoms and jinn possession means that there needs to be more education around the symptoms of mental health problems. Perhaps Muslim men are more familiar with associating these symptoms with possession based theories than having the insight into the same symptoms possibly is in relation to depressive symptoms. As treatment ideas were linked with what the participants understood their actual mental health problem to be, it would be beneficial to bring awareness of the symptoms of mental health problems to the Muslim and Asian communities. It seems first generation and even second generation Muslims might be more likely to engage in therapy if they believe they are in fact experiencing a mental health problem, rather than a jinn possession or a consequence of irregular praying or disconnection from God; increasing awareness around symptoms of mental health problems and therapy being a treatment option would broaden the understanding that Muslim communities currently have. Again, this knowledge of symptoms and treatment could be discussed by counselling psychologists visiting communities in which Muslim populations are high, educating and meeting imams to discuss their important roles in encouraging help seeking behaviours and increasing the understanding that both psychology and religion can coincide.

The identities of the Muslim men were heavily tied with the identity of their family members Therefore, as practitioners, when working with clients from this background, perhaps it would be beneficial to be mindful of the significance of the thoughts and opinions of others from within the community. As well as this, exploring the individual identity of Muslim men and how their image amongst their family and community members might be intertwined with their actions and behaviours could be a topic for consideration in a therapeutic setting.

When working with Muslim men, it is important to recognise that the jinn or possession based explanations derive from religious text rather than paranoia or delusions. The topic of masculinity and what a man should do and what his duties as the head of the house might be could be discussed in a therapeutic setting. Therapists could take this further by assisting them in developing their sense of identity, autonomy and relationships by carefully identifying and evaluating the interactions between the client's individualistic norms and collectivist values in therapy. Differences between first and second generation finding is extremely relevant when working with Muslim male patients as it highlights the importance of recognising that this demographic might be feeling isolated, misunderstood, torn between two cultures and identities and how they may have little to no support from their immediate family members.

4.8 Limitations of study and suggestions for future research

This section will explore the issues, limitations and strengths of this study as well as discussing possibilities for further research. The methodological approach of this study, IPA, could be considered as being a strength to this study as it provides a detailed and coherent account of the participants' experiences of mental health problems from within the context of their faith. Another strength of this study is the contribution that it makes to better understanding an understudied demographic such as second generation Muslim men. It has provided a nuanced understanding of experiences that Muslim men face when processing a mental health problem. Some of these findings have been the stigma and lack of support from family and community, lack of knowledge about mental health problems, difficulties engaging with therapy, the aetiologies of mental health problems being demonic or possession based and alternative Islamic remedies to therapy.

The study found that the normalisation of psychological problems, open discussions around mental health within Asian and Muslim communities and educating and providing knowledge to the communities and school children as well as GP's could benefit Muslim men greatly. Developing such knowledge that practitioners can utilise when working with this demographic is in line with the values of counselling psychology (Strawbridge *et al*, 2010). A further strength of this study is that homogeneity of the sample was achieved by seeing Muslim men who were of the second generation and had been diagnosed with a mental health problem but not seen for therapy.

As well as having strengths, the study also had limitations. Even though the study provides an insight into the participants' experiences, these cannot representative of all Muslim men's experiences with mental health. Furthermore, as qualitative studies consist of a subjective nature, all the conclusions made are the researcher's own interpretations. As the recruitment for this study was incredibly difficult, this reflects the stigma of mental health associated with amongst these communities. Therefore, further research needs to be conducted in the Asian, Arab and Muslim communities to allow for the further exploration of why men do not access help and how they are experiencing their mental health problems.

It might therefore be appropriate to replicate this study with second generation Muslim men of different ages, different ethnicities or complexity of psychological problems as these factors may have an impact on the experiences of mental health problems and how Muslim men view and manage their difficulties. Perhaps it would also be relevant to explore the subjective experiences of Muslim men who have sought and completed therapy in order to examine the differences that might have led to help seeking behaviours. As the study reveals, Muslim men are often discouraged from discussing their problems, therefore it is possible that perhaps the participants could have been more open about their difficulties and their views. Although the researcher is also a Pakistani Muslim, she is also female, which could impact the openness of the participants, therefore it would be valuable to see if a Muslim male researcher yields further findings as the participants might feel more open around him. However, the presence of the female researcher might have meant that the participants were less concerned about upholding their masculine image.

4.9 Reflexive statement part two

The first reflexive statement discussed my thoughts around the critical literature review and pre-recruitment or data collection. This second reflexive statement will give an insight into my thoughts and experiences with the analysis, methodology, data collection/interviews and the results process. Throughout the research, I have kept a reflective diary, used supervision and personal therapy to reflect on my beliefs and assumptions around the participants, views, religion, cultural differences and masculinity. I have attempted to 'bracket' (Smith et al., 2009) my own personal opinions, feelings and understandings as much as I could in order to reduce their influence on the data. I also submitted a random selection of interpretations to my peer researchers from various religious and cultural backgrounds to ensure that my interpretations were grounded within the data.

I did have some concerns during the interviews in regards to how the participants would regard me as a female second generation Muslim who is a trainee counselling psychologist. My identity might have been both a positive and a negative for the study. As a female, perhaps the male participants didn't feel the need to uphold their masculinity and felt more open to sharing their feelings. In contrast, perhaps being female also meant that some of the more religious participants were not as openly expressive, for example lack of eye contact and inquisition would be appropriate cultural responses when in the presence on the opposite gender. Perhaps being from a Pakistani background meant the Pakistani participants found it easier to converse with me, as they would often use random words from Punjabi, Urdu and Arabic languages when discussing their views; this might have allowed the participants to have felt more rapport with me than if they were being interviewed by someone who could not speak these languages.

Whilst conducting this research, I have been encouraged to reflect on my own identity as the participants so regularly did during the interview process. I felt myself able to empathise with them greatly when they openly discussed the difficulties of being caught in the middle of both their cultures. I was born and raised in the UK but my parents were both born and raised in Pakistan and came to the UK in their twenties. As a second generation Pakistani Muslim female, I could see how the participants were often confused with the conflicting expectations of each culture and how this can have an impact on mental health as well as all aspects of one's life. The bicultural expectations can be conflicting, and in addition to this there are also the religious expectations that can be contradictory at times to cultural viewpoints. Therefore, when the participants explained feeling confused at times, I could relate to them entirely.

As I was aware of the above, I did not want my personal views to reflect the thoughts of the participants. Therefore I discussed with peer researchers when trying to identify my themes, to ensure that the themes being identified were reflective of the participants' experiences and not mine. I also continued to use my personal therapy to discuss my own identity further so that I was more conscious of my own beliefs and views, in addition to this I also continued to keep the reflective journal to further increase my own awareness.

Even though I felt myself feeling empathic and a sense of familiarity with the participants for the majority of the interview, there were moments when the participants' views were very different to my own. For instance, when

two of the participants suggested the causes of mental health problems to be a disconnection from God or spoke about demonic based possession causing auditory hallucinations, I felt slightly frustrated. I was able to become aware of this and at this point I did not interrupt the participants whilst they were discussing their views and tried my best to not give any indication that I have a different opinion to them on the matter. I believe my own frustration might have stemmed from seeing family members have mental health problems and it also being blamed on Jinn or the lack of closeness to God. Again, these feelings were taken to personal therapy and written about in my journal.

Even though one can be acutely aware of their own thoughts and beliefs, it is impossible to block out my own cultural understanding and experiences completely. At times I found myself during the analysis stage trying to find supportive statements that suggest Muslim men recognise mental health problems as being psychological issues; reflecting on this in supervision helped me in improving my objectivity and reflectivity by recognising the influence my identity as a trainee counselling psychologist was having on the analysis.

I have learnt a great deal during this research. From my past experiences, Muslim men have not been so forthright in discussing their mental health problems, so I was pleasantly surprised when the participants seemed to open up during the interviews and even asked questions afterwards in regards to where they could more information and seek support – this made me feel quite happy and relieved that second generation Muslim men did value and see the importance of therapy and that perhaps the interview process opened their minds to the possibilities that their faith and psychology can coincide. I was also reassured that none of the participants stated that psychology or therapy or mental health were concepts that go against Islamic teachings, perhaps again, as the participant stated, this might be because they have the influence of the West, whereas their parents were not introduced to these concepts.

As I also have parents who are first generation Pakistani immigrants, I can understand the participant's difficulties with trying to explain their problems or mental health in general to this generation. However, it was quite refreshing to hear that some of the participants still try and educate and provide knowledge to their parents about these matters in an effort to change their perspectives.

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APPENDIX

APPENDIX A: (Research poster):

Are you a Muslim, man interested in taking part in psychological research?

As part of a research project at London Metropolitan University, we will be looking at:

How do second generation Muslim men experience mental health problems within the context of their faith? An IPA study.

We would kindly ask that you be available for an interview of no longer than one hour. The interview will involve a one to one semi structured format with a trainee counselling psychologist, in which you have the opportunity to discuss something that you may not have previously been able to talk about.

We are looking for male, Muslim participants between the ages of 18 to 65 who were born in Britain and have experienced a mental health problem. Once you have taken an initial questionnaire, you will be invited to an interview where you can share your thoughts and feelings on psychological wellbeing from an Islamic perspective.

If you are interested, please email the researcher, Sara Chaudhrey, on: sac1038@my.londonmet.ac.uk, we will then be in contact with you.

Supervisor's email address: a.loulopoulou@londonmet.ac.uk

Thank you.

APPENDIX B: PHQ9 psychometric tool:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

APPENDIX C: Information sheet:

As part of a research project at London Metropolitan University, we will be looking at:

How do second generation Muslim men experience mental health problems within the context of their faith? An IPA study.

(We will kindly ask that you read this information sheet carefully before agreeing to participate).

STEP 1:

Carrying out a PHQ-9 questionnaire.

STEP 2:

Carrying out a one to one semi structured interview with the researcher and trainee counselling psychologist. This interview will be audio recorded and all data will be kept anonymous if and when used in a study. All data is kept on an encrypted recording device and an encrypted USB stick.

The interview will yield questions around what you view mental health to be and how you relate to it as a Muslim. What are your thoughts about psychological wellbeing? Do you think mental health has a place in Islam?

The information you provide will be analysed and coded.

STEP 3:

If required, questions and answers that you may have after the interview has been conducted.

Thank you for your time!

If you should have any questions at this stage, please ask the researcher.

APPENDIX D: Consent form:

Consent form

Full title of Project: How do second generation Muslim men experience mental health problems within the context of their faith? An IPA study.

Name, position and contact address of Researcher: Sara Chaudhrey, Trainee counselling psychologist, London metropolitan university, email: sac1038@my.londonmet.ac.uk

	Please Initial Box
1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I Am free to withdraw up to one month after the interview, at any time, without giving reason.	☐
3. I agree to take part in the above study.	☐
4. I agree to the interview consultation being audio recorded	☐
5. I agree to the use of anonymised quotes in publications	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

APPENDIX E: Interview schedule:

1. What are your views of mental health?
2. What do you think are the views of Islam on mental health?
3. What is it like being a Muslim man and talking about mental health problems?
4. How do you view mental health problems?
5. In what way(s) do you think being male and being Muslim influence your understanding of mental health?
6. And what is your opinion about that?
7. What do you think are the causes of psychological problems?
8. What do you think would help someone get better?
9. And do you think that is what Islam recommends too?
10. What do you think the views of mental health are in society at present?

APPENDIX F: Debrief form:

Debrief form

Thank you for participating as a research participant in the present study concerning your views of Muslims men's experiences of their mental health problems from within the context of their faith.

Again, we thank you for your participation in this study.

If you know of any friends or acquaintances that are eligible to participate in this study, we request that you not discuss it with them until after they have had the opportunity to participate. Prior knowledge of questions asked during the study can invalidate the results. We greatly appreciate your cooperation.

If you have any questions regarding this study, please feel free to ask the researcher at this time.

In the event that you feel psychologically distressed by participation in this study, we encourage

you to email Dr. Angela Loulopoulou, Department of Psychology, London Metropolitan University: a.loulopoulou@londonmet.ac.uk

Please remember, that you have one month to withdraw from this study, should you wish to do so.

Thanks again for your participation.

APPENDIX G: Distress Protocol

Protocol to follow if participants become distressed during participation in the study:

This protocol has been devised by Cocking, (2008) to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the current research study on the exploration of second-generation, Indian, Hindu women's' experiences of engaging in cross-cultural romantic relationships. If distress were to occur during participation in the study, the researcher, Sara Chaudhrey, is a counselling psychologist in training at London Metropolitan University and has experience in managing situations where distress may occur. Outlined below is a three step protocol detailing signs of distress that the researcher will look out for, as well as the necessary action to take at each stage. It is not expected that extreme distress will occur, or that the relevant action will become necessary and participants are advised to inform the research should they wish to take a break or stop the interview.

Mild distress

Signs to look out for:

1) Tearfulness

2) Voice becomes choked with emotion/ difficulty speaking

3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue

2) Offer them time to pause and compose themselves

3) Remind them they can stop at any time they wish if they become too distressed

Severe distress

Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently

2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack

3) Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1) The researcher will intervene to terminate the interview/experiment.

2) The debrief will begin immediately

3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation

4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions

5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction

6) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression

2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

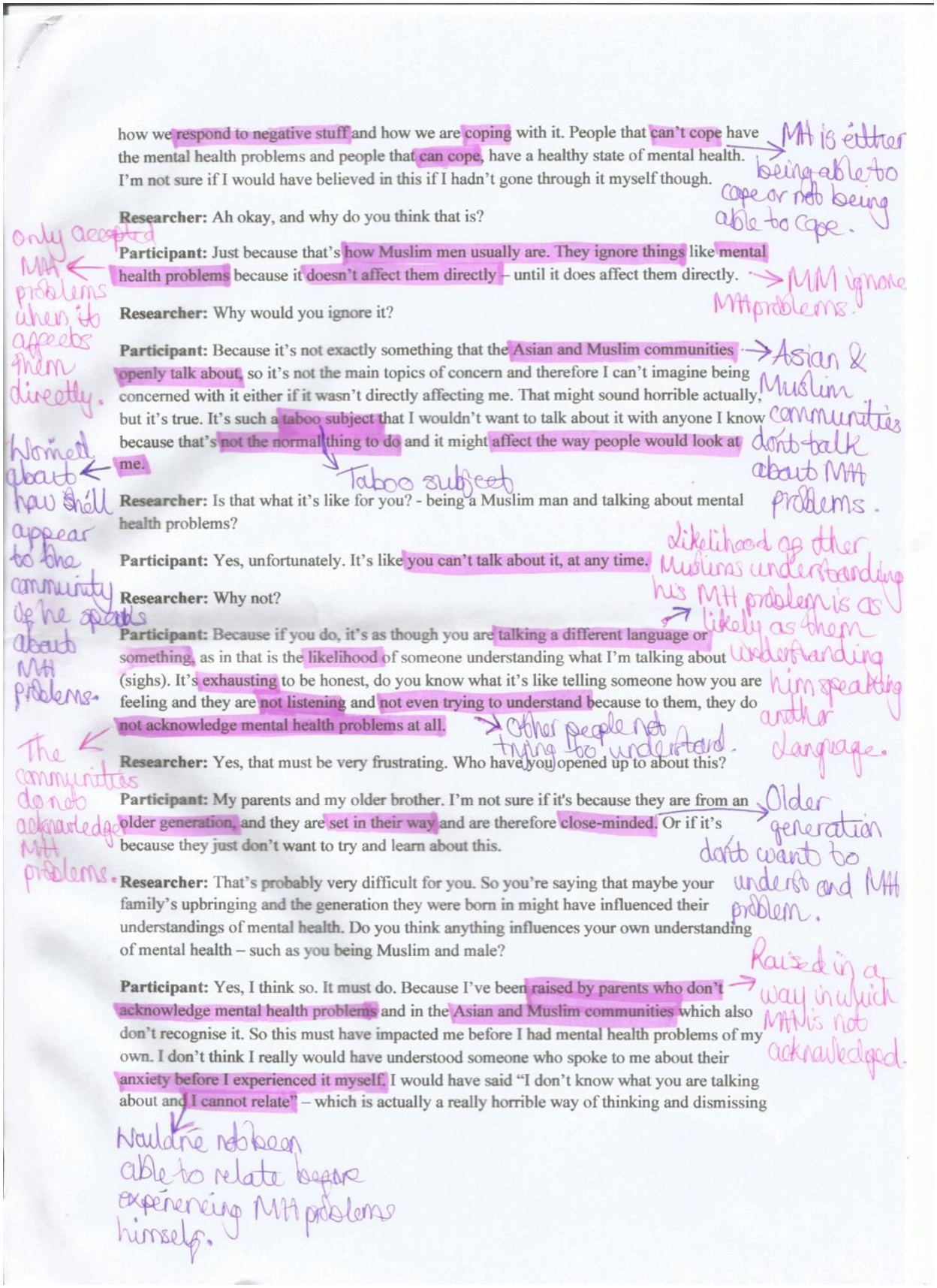
1) Maintain safety of participant and researcher

2) If the researcher has concerns for the participant's or others' safety, he will inform them that hehas a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.

3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team. If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment.

(This last option would only be used in an extreme emergency).

APPENDIX H: Annotations of transcript from emerging themes from participant two (Adam): Exploratory comments were noted on the left hand side. Emergent themes were



how we respond to negative stuff and how we are coping with it. People that can't cope have the mental health problems and people that can cope, have a healthy state of mental health. I'm not sure if I would have believed in this if I hadn't gone through it myself though.

Researcher: Ah okay, and why do you think that is?

Participant: Just because that's how Muslim men usually are. They ignore things like mental health problems because it doesn't affect them directly – until it does affect them directly.

Researcher: Why would you ignore it?

Participant: Because it's not exactly something that the Asian and Muslim communities openly talk about, so it's not the main topics of concern and therefore I can't imagine being concerned with it either if it wasn't directly affecting me. That might sound horrible actually, but it's true. It's such a taboo subject that I wouldn't want to talk about it with anyone I know because that's not the normal thing to do and it might affect the way people would look at me.

Researcher: Is that what it's like for you? - being a Muslim man and talking about mental health problems?

Participant: Yes, unfortunately. It's like you can't talk about it, at any time.

Researcher: Why not?

Participant: Because if you do, it's as though you are talking a different language or something, as in that is the likelihood of someone understanding what I'm talking about (sighs). It's exhausting to be honest, do you know what it's like telling someone how you are feeling and they are not listening and not even trying to understand because to them, they do not acknowledge mental health problems at all.

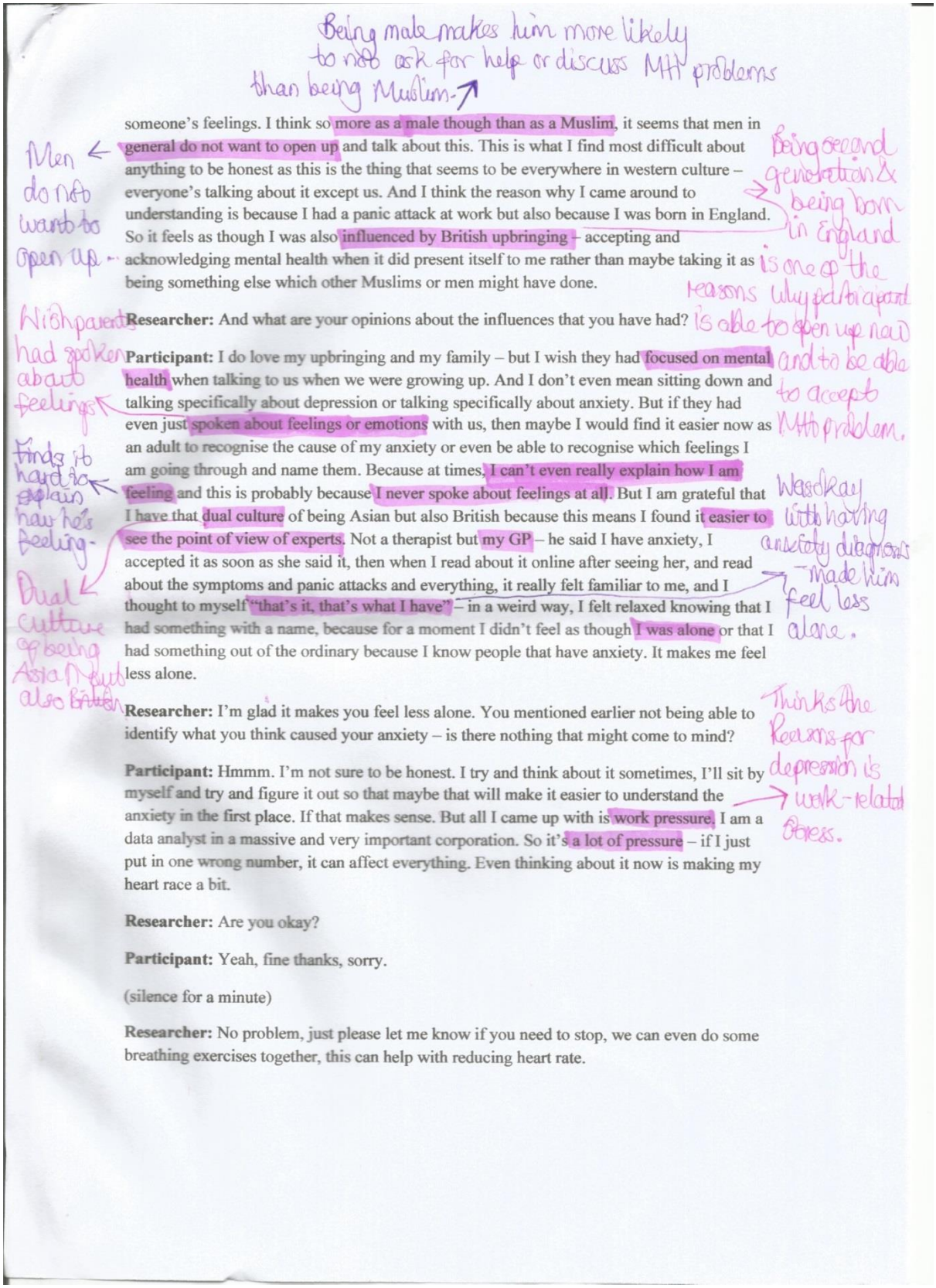
Researcher: Yes, that must be very frustrating. Who have you opened up to about this?

Participant: My parents and my older brother. I'm not sure if it's because they are from an older generation, and they are set in their way and are therefore close-minded. Or if it's because they just don't want to try and learn about this.

Researcher: That's probably very difficult for you. So you're saying that maybe your family's upbringing and the generation they were born in might have influenced their understandings of mental health. Do you think anything influences your own understanding of mental health – such as you being Muslim and male?

Participant: Yes, I think so. It must do. Because I've been raised by parents who don't acknowledge mental health problems and in the Asian and Muslim communities which also don't recognise it. So this must have impacted me before I had mental health problems of my own. I don't think I really would have understood someone who spoke to me about their anxiety before I experienced it myself. I would have said "I don't know what you are talking about and I cannot relate" – which is actually a really horrible way of thinking and dismissing

noted on the right hand side of the transcript. A list of emergent themes was created for each of the participants.



someone's feelings. I think so more as a male though than as a Muslim, it seems that men in general do not want to open up and talk about this. This is what I find most difficult about anything to be honest as this is the thing that seems to be everywhere in western culture – everyone's talking about it except us. And I think the reason why I came around to understanding is because I had a panic attack at work but also because I was born in England. So it feels as though I was also influenced by British upbringing – accepting and acknowledging mental health when it did present itself to me rather than maybe taking it as being something else which other Muslims or men might have done.

Researcher: And what are your opinions about the influences that you have had?

Participant: I do love my upbringing and my family – but I wish they had focused on mental health when talking to us when we were growing up. And I don't even mean sitting down and talking specifically about depression or talking specifically about anxiety. But if they had even just spoken about feelings or emotions with us, then maybe I would find it easier now as an adult to recognise the cause of my anxiety or even be able to recognise which feelings I am going through and name them. Because at times, I can't even really explain how I am feeling and this is probably because I never spoke about feelings at all. But I am grateful that I have that dual culture of being Asian but also British because this means I found it easier to see the point of view of experts. Not a therapist but my GP – he said I have anxiety, I accepted it as soon as she said it, then when I read about it online after seeing her, and read about the symptoms and panic attacks and everything, it really felt familiar to me, and I thought to myself "that's it, that's what I have" – in a weird way, I felt relaxed knowing that I had something with a name, because for a moment I didn't feel as though I was alone or that I had something out of the ordinary because I know people that have anxiety. It makes me feel less alone.

Researcher: I'm glad it makes you feel less alone. You mentioned earlier not being able to identify what you think caused your anxiety – is there nothing that might come to mind?

Participant: Hmmm. I'm not sure to be honest. I try and think about it sometimes, I'll sit by myself and try and figure it out so that maybe that will make it easier to understand the anxiety in the first place. If that makes sense. But all I came up with is work pressure. I am a data analyst in a massive and very important corporation. So it's a lot of pressure – if I just put in one wrong number, it can affect everything. Even thinking about it now is making my heart race a bit.

Researcher: Are you okay?

Participant: Yeah, fine thanks, sorry.

(silence for a minute)

Researcher: No problem, just please let me know if you need to stop, we can even do some breathing exercises together, this can help with reducing heart rate.

Participant: Oh really! I didn't know that. I don't think I need it right now but I wouldn't mind being shown a breathing exercise for later.

Researcher: Yes, no problem, we can go through that after the interview. I'd be happy to show you.

Participant: Thanks.

Researcher: You're welcome. So, you were saying that you think that maybe your job was the cause of your anxiety?

Participant: Yeah, I really think it is. But then I think, I'm pretty sure I was anxious at university too, especially during exams and if there was a party or something, I'd get nervous. But not just a normal level of being nervous – this was like I couldn't breathe because I was so worked up and it just wouldn't stop, no matter what I did.

Researcher: Thank you for sharing that with me, I can see how hard that might have been for you. What do you think Islam thinks the causes of mental health problems are?

Participant: I feel like there are two points of view. One is what Muslims think and another is what Islam thinks. Just because Islam says something might be a certain cause of mental health problems, that doesn't necessarily mean that Muslims take the same stance. In my experience, Muslims would probably think it's because you are not praying enough, as in not reading the Quran enough or not reading Salah (prayer) enough as it's recommended, which is five times a day. Or they might think it's something to do with the devil. He has the capability of making people feel angry, depressed or negative so I guess he also has the ability to make people feel anxious – I actually agree with this but for other people. I don't think this is what's causing my own anxiety.

Researcher: That's interesting, and what was the view of Islam then in your opinion?

Participant: Actually, I think it is similar (laughs). I think Islam pretty much has the same ideas. That remembering God and reading the Quran and praying should make you feel better. This is the most I can remember to be honest in regards to the mental health and the Quran. I'm pretty sure there are verses that speak about trying to feel at peace and trying to connect with God by doing good towards other people too – but I think the main focus is the relationship between a person and God and if this is strengthened, and the person can feel at peace when talking to God, then this should make them feel less anxious and more able to cope with negative things that life throws at them. Because God acts as a support system, religion – Islam, acts as a support system, it's supposed to give you hope and faith and power to continue.

Researcher: Does Islam do this for you?

Participant: That's tricky to answer, because I don't think I engage with reading the Quran and praying as much as I should to be able to decide that. But then again, when I do pray and talk to God, it does make me feel relaxed and less anxious. I often ask God to help me

APPENDIX I: Preliminary table with themes

Superordinate themes	**Subordinate themes**
Unsupportive roles of others (family and community)	**Family members not understanding**
	Friends not understanding
	Community members not understanding
Stigma within religious and cultural communities	**Reputation being diminished**
	Being judged
	Stigma around seeking therapy
Religious guilt and shame	**Lack of religious devotion being the cause of mental health problems**
	Ungrateful to God
	Punishment from God
	Asking God for help
Masculinity and Islam	**Religious responsibilities**
	Vulnerability and weaknesses
	Secrecy
Generational differences	**Influence of British culture**
	First generation Muslims
The role of devil and Jinn	**Possible causes of mental health problems**
	How to treat mental health problems from Islamic perspective

APPENDIX J: Approval of ethics email confirmation, dated 30/01/2018:

Apporoval of Ethics Application form Inbox ×

Angela Loulopoulou <A.Loulopoulou@londonmet.ac.uk> Tue, Jan 30, 2018, 12:57 PM

to me

Dear Sara,

Both the Reviewer appointed by the Review Ethics Committee and the Head of Research have approved your Ethics Application proposal. You can proceed with the interviews and data collection for your study.

Kind Regards,

Angela

Chair of Review Ethics Committee for PG Psychology

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Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA

Principal Lecturer in Counselling Psychology
Programme Director of the Professional Doctorate in Counselling Psychology
School of Social Sciences
Chair of Subject Standards Board for PG Psychology
Chair of Review Ethics Committee for PG Psychology