

Exploring the perception of mental illness among South African Muslim students

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Abstract

There is a growing interest in adapting psychology to non-Western cultures. This is of particular importance in South Africa with its culturally diverse population. Looking to non-Western cultural approaches to psychology can provide insight into what changes may need to be integrated into mainstream psychology. Islam has a rich psychological tradition that makes it a good candidate for research aimed at increasing the inclusiveness of mainstream psychology. In order to further this aim, the current study investigated the perceptions of Muslim students around the topic of mental illness and psychology. Four focus groups of between five and eight undergraduate psychology students were conducted using a semi-structured approach. The resulting data were analysed using thematic analysis within a constructionist framework and three main themes were identified. Three main themes were identified around stigma, the use of faith in treating mental illness and on the interaction of Islam with psychology. Participants held conflicting views on the use of prayer as an intervention for mental illness and on the integration of Islam into psychotherapy. Ultimately the results suggested that rather than attempting to integrate Islam into psychology, psychologists should instead aim to learn about Islamic culture in order to better understand their Muslim clients.

Keywords: Islam; Muslim clients; mental illness; psychology; thematic analysis; South Africa

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Introduction

A common issue faced by psychology in the world today is the need to adapt to multicultural societies (Haque & Kamil, 2012). Mainstream psychology is a product of Western culture and as such is not always equipped to serve the needs of non-Western communities. This is a particularly salient issue in South Africa, where psychology has been accused of not being relevant to the needs of most of the population (Nell, 1990). Nell (1990) suggests that mainstream psychology needs to be expanded to include different approaches in specific areas of need. One way to begin this process of integration is to look to the psychological traditions found in other cultures. Islam is of particular interest since it has a rich psychological tradition of its own (Haque, 2004a) and while in the minority in South Africa, it nevertheless has a significant presence (Vahed, 2007). Very few studies on the topic of mental health in Muslim communities exist (Abu-Raiya & Pargament, 2011), and the few that do exist indicate that in Western countries Muslim populations underuse mental health services (Weatherhead & Daiches, 2010). Among other things, this suggests that mainstream psychology is failing to meet the mental health needs of Muslims. Studies in South Africa are virtually non-existent, and it is difficult to generalise international results to local Muslims. Studies conducted in Western countries involve immigrant populations whereas the South African Muslim population is well-integrated into South African society (Quinn & Quinn, 2003). This creates some important differences between Muslim populations in South Africa and those overseas. The proposed study seeks to investigate some of the barriers that exist between the two traditions with a view to developing ways of integrating some of the principles of Islamic psychology into Western psychology.

Islamic Psychology

Islam has a long and complex psychological tradition, and one that has not experienced the West's division between religion and psychology (Skinner, 2010). It takes a holistic view of the person as a dynamic balance between the body, the inner heart, self, intellect and spirit (Haque, 2004a). When an imbalance occurs between these entities, the person experiences illness, either physical or spiritual (Skinner, 2010). By the same token, treatment may involve an intervention that is physical, spiritual or both (Ally & Laher, 2008). Faith is considered a powerful healer and essential to recovery (Youssef & Deane, 2006). Perhaps more importantly, illness can be perceived as a symptom of distance from God which should be treated by restoring faith and a sense of closeness to God (Haque, 2004a). Therefore choosing to see a psychologist may be perceived as both compounding the issue of distance from God

and as a betrayal of faith (Weatherhead & Daiches, 2010). However it is not only in the area of health that Islam integrates religion: rather, it permeates all aspects of life. The Quran provides instructions for living covering a variety of areas from dress and food to investment and marriage laws. It provides guidance on how to live a good life by outlining moral values, encouraging certain personal qualities such as patience and faith and discouraging negative emotions such as anger. Family is deeply valued within Islam and is also a source of support in times of trouble (Haque, 2004b).

This integration of God into everyday life and the self can be difficult for psychologists to relate to. Western culture is generally a secular one, and psychology has an uneasy relationship with religion (Tarakeshwar, Stanton, & Pargament, 2003). In its early days psychology was faced with the tasks of separating itself from philosophy and establishing itself as a science. Since religion was irrelevant to science and tied to philosophy, this meant that psychology needed to distance itself from religion (Haque, 2001). Since the 1960s this picture has changed, and the psychology of religion is now a popular area of research (Emmons & Paloutzian, 2003). Studies show that religion is both vital to understanding human nature (Tarakeshwar et al., 2003) and strongly linked to both physical and mental health (Carone Jr & Barone, 2001; Emmons & Paloutzian, 2003). Yet despite this psychology entertains a reluctance to integrate religion into the appraisal and treatment of mental health issues (Tarakeshwar et al., 2003). Given the Islamic integration of religion into everyday life, a Muslim client's interpretation of mental illness is likely to incorporate their faith. For a treatment to be successful, it too would need to do so (Weatherhead & Daiches, 2010). Without some knowledge of Islam and an ability to integrate its principles into treatment, it is unlikely that a Western practitioner could provide the help that is needed (Cinnirella & Loewenthal, 1999). While this goes some way to explaining the reluctance among Muslims to see psychologists, a number of other issues have been identified.

International Studies

Studies in Western countries consistently find that mental health services are underused by Muslims (Weatherhead & Daiches, 2010; Youssef & Deane, 2006). One finding in both the United Kingdom and Australia was that mental illness was thought to originate from a variety of sources, including witchcraft, punishment by God or a lack of faith (Weatherhead & Daiches, 2010). In an Australian Arab sample (Youssef & Deane, 2006) a clear distinction existed between more serious mental disorders such as schizophrenia and milder forms such as anxiety. While anxiety was seen as an acceptable response to life events, schizophrenia

was heavily stigmatised. The issue of stigma emerged in a number of studies, and was an important concern among Muslims (Ciftci, Jones, & Corrigan, 2013; Weatherhead & Daiches, 2010). Private issues were kept within the family, and the disclosure of such matters to those outside the family was seen as shameful (Ciftci et al., 2013). However it must be noted that these studies were all conducted among immigrant populations living in countries with a dominant Western culture. It is likely that belonging to an immigrant group in a foreign country contributed to a reluctance to seek mental health care. The same cannot be said of Muslims in South Africa, who have a history dating back to the 1600s (Quinn & Quinn, 2003).

Islam in South Africa

Unlike recent immigrants in countries such as the United States, Muslims in South Africa are fairly well integrated in terms of language and general culture (Quinn & Quinn, 2003). They are however very much in the minority, consisting of 1.5% of the population (Vahed, 2007). Muslims in South Africa come from a variety of ethnicities, classes and languages and as a result of apartheid these divisions run deep (Nadvi, 2008; Vahed, 2007). Different subsets of the Muslim population had different reactions to Apartheid - some rebelled against it while others chose to remain neutral (Quinn & Quinn, 2003). Following apartheid, Muslims in South Africa were faced with redefining their identities along religious as opposed to political lines (Nadvi, 2008; Vahed, 2007). As a result, Muslims in South Africa form distinct subgroups within which attitudes and traditions may differ. Little is known about how mental health is perceived among the various subgroups of South African Muslims, or globally among non-immigrant and more secularised Muslims.

Psychological research involving Muslims is scarce internationally (Sheridan & North, 2004) and almost non-existent in South Africa. In one South African study involving Muslim faith healers (Ally & Laher, 2008), illness was perceived as having two possible causes, either mundane or spiritual. Illnesses with mundane causes were considered to fall within the domain of Western practitioners. For spiritually caused illnesses, treatment from a doctor or psychologist was considered insufficient since it would only mask the symptoms. In order to cure the illness, a spiritual intervention would be required to remove its source. Islam was an integral part of how this sample perceived the psychological makeup of a person, the sources of potential illness and treatment options. However there was also an emphasis on collaboration with other practitioners.

Another South African study involving Muslim lay counsellors (Laher & Khan, 2011) found a similar mesh between Islamic and Western psychology. While the counsellors understood mental illness from a Western psychological perspective, they integrated this with an Islamic view of the self. Treatment involved both Western counselling techniques and Islamic religious interventions. Another issue that was identified was that of stigma around mental illness in Muslim communities. These results indicate that Muslim practitioners have integrated Western psychology into their practice. However this may simply be a result of working in the mental health field. No studies exist in South Africa involving Muslim laypeople, and rates of uptake of mental health services among Muslims in South Africa are unknown.

Conclusion

While research in Western countries indicates low uptake of mental health services among Muslims, it is unclear whether this is the case in South Africa. The general lack of psychological research involving Muslims has led to an incomplete picture of how they engage with mental illness. Islam has a strong psychological tradition that is largely ignored by Western psychology. International studies involving immigrant groups suggest a lack of confidence in Western psychology and issues with stigma keep Muslims from seeking mental health care. However Muslims in South Africa differ from international immigrant populations in that they are well established and have had centuries to integrate into South African society. Very little is known about how Muslims in South Africa view mental illness and its treatment. No research exists involving South African Muslim laypeople which makes it difficult to judge how Muslims perceive Western psychologists. Research in this area could provide insight into the ways South African psychology needs to adapt in order to provide help to people from other cultures.

Aims

The issue of the relevance of psychology to non-western cultures is a growing concern in an increasingly multicultural world. It has been suggested that psychology is not in need of being reinvented for different cultures, but rather that specific issues need to be handled from within a single psychology (Nell, 1990). The overall aim of this project is to look at Muslims as an example of a minority culture with its own psychological tradition that has been largely ignored by mainstream psychology. The primary aim of the project is to investigate how Muslims understand psychology and integrate it into their world view, more specifically, how

they understand mental illness and its treatment. A secondary aim is to gain insight into how mainstream psychology could be adapted in order to better fit the needs of Muslims.

The research question can be formally stated as: How is mental illness and its treatment understood among South African Muslims?

Theoretical Framework

A social constructionist approach will be taken in this project. The theory of social constructionism was developed in response to growing dissatisfaction with empirical approaches to understanding the world (Kuhn, 2003). While empiricism supported the idea that reality could be mirrored through research, constructionists believed that reality could not be accessed directly (Gergen, 1985). Instead, it was interpreted and shaped by the tools of human understanding – language, categories and negotiation with other people (Gergen, 2009). Constructionism does not entail a denial of an independent reality, rather it suggests that reality is understood and given meaning through the process of social interaction. In this way an individual's lived reality is formed of concepts constructed through language, and it is to these concepts that they relate, rather than directly to an objective reality (Hacking, 1999). One consequence of the constructionist approach to understanding the world is the insight that the way an entity is constructed is negotiable (Gergen, 1985) and is a result of its historical and cultural context. This can be observed in the variety of ways reality is constructed across different cultures (Gergen, 2009).

Issues such as religion or psychological understanding are closely linked to cultural and social concepts (Engler, 2004), making this project a good candidate for constructionism. Islamic psychology comes from a different cultural and historical context to mainstream psychology and a constructionist approach will take those differences into account. The aim will be to understand both the current state of psychology in Muslim communities and the social processes behind it. Ultimately constructionism points to the fact that there is not one reality, but rather many realities and no single version is necessarily better than the others (Madill, Jordan, & Shirley, 2000). This approach means that Islamic psychology can be approached in an open-minded way with the intention of understanding it from within its own context rather than a western one. Constructionism also openly acknowledges the role played by the researcher in co-constructing the research results (Cunliffe, 2003). From the design of the questions to the data collection itself, the researcher's choices and interpretations will become part of what the research produces. All research requires an awareness of the researcher's influence, however within the constructionist paradigm this is not an issue to be

eliminated as far as possible, but is accepted as an inevitable part of the process (Madill et al., 2000).

Methods

Sampling Strategy

Qualitative research generally relies on purposive sampling procedures (Devers & Frankel, 2000). The aim is to locate participants who embody the quality or living conditions under study (Coyne, 1997). Alternative methods are to look for deviant cases or exceptions to the rule in order to refine the data produced (Devers & Frankel, 2000). The sample chosen dictates the quality of the data produced, and as such the aim is to select cases that are likely to provide the richness of detail needed. However, negotiating access to participants can be time consuming (Coyne, 1997). Given the limited scope of the current project, a convenience sample of university students was recruited. Advertisements for Muslim participants were placed on two websites, the Student Research Participation Program (SRPP) and the Muslim Student Association (MSA). Undergraduate psychology students are required to earn a certain number of points by participating in research and this is managed via the SRPP website. A total of 25 participants were recruited, 22 of which were found through the SRPP site and 3 through the MSA site. The sample was predominantly female, with 4 male participants, and ages ranged from 18 to 48 with all but one participant under the age of 22.

Data Collection

Data collection was done using focus groups. Qualitative research encompasses a variety of data collection strategies, each with its own strengths and weaknesses. Focus groups have been gaining in popularity over recent years, and provide a unique way of gathering data (Willig, 2008). Groups of roughly between six and ten participants are gathered together to discuss a set of questions. Participants are encouraged to talk to one another and to discuss questions as a group, rather than simply speaking to the researcher (Morgan, 1996). A unique feature of focus groups is the way that group participants interact with one another (Kitzinger, 1994). Participants can ask each other for explanations, clarify views and explore each other's understanding of a particular topic (Morgan, 1996). This allows the group's dominant views to emerge and provides insight into norms held by the group (Smithson, 2000). One issue with this is that participants with differing views may be silenced by the dominant voice of the group; however this can be compensated for by encouraging participants to bring up dissenting views (Kitzinger, 1995). Focus groups work well within a

social constructionist framework since they can show construction in action through the language and negotiation of concepts used by the participants (Willig, 2008).

Particularly when studying cultures, focus groups provide an environment where participants can display the language, concepts and shared knowledge held by their cultural group (Hughes & DuMont, 2002). Focus groups also go some way towards evening out the power imbalance between researcher and participant (Puchta & Potter, 1999). This can be of particular concern when working with minority cultural groups (Smithson, 2000), and the fact that there are several participants to one researcher may allow participants to feel empowered and better able to be open about their views (Morgan, 1996). Given the choice of using Muslim participants in the current study and the minority status of Muslims in South Africa, focus groups were considered a particularly appropriate method of data collection.

Data were collected through four focus groups of between five and eight participants, each of which lasted one hour. Each participant attended a single focus group. The questions used for the focus group were an important part of guiding the group through the topic under investigation, and a semi-structured approach was taken with half a dozen questions (see Appendix D). I moderated the groups and participants were encouraged to explain and discuss their views. The aim was to provide the group with the space to explore issues in a way that allowed unexpected directions to be taken. Given the relatively under researched nature of the topic, this approach provided the opportunity for new information to emerge. The meetings took place in a room in the psychology department and were audio recorded.

Data Analysis

The data were analysed using thematic analysis as outlined by Braun and Clarke (2006). Although commonly used in qualitative research, thematic analysis was for a long time unacknowledged as a data analysis method in its own right (Braun & Clarke, 2006). Braun and Clarke (2006) challenged this perception and suggested that thematic analysis was in fact a powerful and flexible method that could be used within a variety of theoretical frameworks. One strength of thematic analysis is its simplicity, making it a good choice for those with little experience in qualitative research. However, its flexibility means that when using thematic analysis, it is important to state one's theoretical approach since the method of analysis does not reveal this in the way that some other methods do. The way the techniques of thematic analysis are applied vary depending on the aims and theoretical background of the research and therefore these decisions need to be made explicit (Braun & Clarke, 2006).

In the current project thematic analysis was used within a constructionist framework to look at how participant interaction shaped the data. Rather than searching for a single truth within the data, it was analysed with an eye for contradiction in order to reflect the different ways in which participants made sense of the topic. The process of familiarisation began with the transcription of the data, and was then continued with multiple readings of the data. The data were then coded in order to identify potential patterns or specific items of interest. Once coded, the data were analysed for potential themes and sub themes with the aim of producing a thematic map of the data. Themes were checked against the data and each other to ensure distinctiveness and accuracy (Braun & Clarke, 2006). Finally the analysis was written on the basis of the identified themes. Given the social constructionist approach of this project, the data were not treated as a direct reflection of reality (Braun & Clarke, 2006), but instead were read with multiple possible interpretations in mind.

Reflexivity

When conducting research, it is important to remember the part played at every stage of the process by the researcher's identity, assumptions, and socio-cultural location (Mauthner & Doucet, 2003). From choice of topic, to data collection to analysis, it is important to be aware of what decisions are being made and why, as well as what choices were not taken (Archer, 2002). The researcher makes decisions about which questions to ask and how to phrase them (Willig, 2008), which themes to focus on and which to ignore (Mauthner & Doucet, 2003). His or her identity can influence what information is provided by the participants. Reflexivity is how the researcher informs his or her audience of decisions made throughout the research, allowing them to judge the results more accurately (Horsburgh, 2003). Particularly from a constructionist perspective, it is important to acknowledge and identify the role the researcher plays in the construction of the research (Pillow, 2003).

In the current project I was dealing with participants of a different generation, ethnic group and religion. As the researcher I was already in a position of relative authority, and my being in my mid-thirties added to this. However the focus group situation appeared to successfully diffuse this imbalance since participants outnumbered me, which may have allowed them to feel more at ease. An initial reticence in the groups generally faded after the first ten minutes of discussion. In addition to this, my being white and non-Muslim further contributed to the divide between the participants and myself. Had the discussions been around the topic of race, my being white may have had an important influence, however this was not the case. Previous research among Muslims supports the idea that interviewer race

only affected discussions around race (Archer, 2002). As far as my being non-Muslim went, I initially had concerns that this would inhibit discussions around faith. However each focus group consisted of a mix of cultural sub-groups, generally either of Indian or Cape Malay descent. Had I been Muslim, I would have fallen within one of these sub-groups which may then have inhibited participants belonging to different sub groups. Instead I was in a sense neutral allowing all participants an equal voice. However my being non-Muslim did surprise some of the participants, who wondered why I would choose to research this particular topic. I explained that my decision was based on my familiarity with Islam which came about primarily as a result of spending my schooling years in a majority Indian country. This may have reassured participants that although I was not Muslim, I was more likely to be open minded and understanding of their points of view.

Ethics

Research ethics generally consist of three basic principles: autonomy, beneficence and justice (Orb, Eisenhauer, & Wynaden, 2001). The principle of autonomy requires that participants be treated as independent and capable of making their own decisions (Orb et al., 2001). In the current study this principle was implemented in the form of informed consent and the right to withdraw from the study at any time without negative consequences. Participants signed informed consent forms for the study as well as consent for audio recording and transcribing (see Appendices B and C). They were informed of their right to withdraw at any time and were debriefed at the end of the focus group. Beneficence requires that the participants' best interests be kept in mind (Orb et al., 2001) which was implemented through the use of pseudonyms, the protection of data and the provision of information to the participants about how their data would be used. The principle of justice requires that participants receive benefits from the research in proportion to the burden the experience (Orb et al., 2001). This study implemented this principle by providing participants with two SRPP points in exchange for an hour of their time. Those that came via the Muslim Student Association expressed the desire to contribute to this under-researched area and thus perceived this as a benefit to taking part.

Due to its very nature, qualitative research can also present certain ethical challenges. For example, it is not always certain how the research will unfold. While participants can be given some detail, qualitative research can take unpredictable turns. As such, ethical guidelines need to be kept in mind throughout the process and revisited if circumstances change (Guillemin & Gillam, 2004). A variety of potential ethical challenges may occur. It is

possible that participants may express views that offend other group members. It is also possible that participants may share sensitive information and regret doing so in front of the other group members. Ethically speaking it is necessary to be able to respond to situations as they arise (Guillemin & Gillam, 2004). In order to address potential concerns about having disclosed too much information, participants were asked to keep the discussions confidential. The discussions did not become overly argumentative and participants were respectful of one another, therefore there is minimal risk of participants having taken any harm from the process. Another point to consider is that participant data should not be distorted to fit the researcher's interests, and should not be used simply for the sake of voyeurism (Karnieli-Miller, Strier, & Pessach, 2009). The analysis was therefore conducted with an eye to accurately reflecting the participants' stance and data was chosen carefully for its relevance and not for the curiosity value of revealing intimate details about participants' experiences.

Results and Discussion

Three main themes were identified from the data: (i) the stigma of mental illness; (ii) prayer and the treatment of mental illness; and (iii) the interaction of Islam and psychology. The second theme, 'prayer and the treatment of mental illness' is further divided into two sub themes: (i) faith as therapy; and (ii) prayer isn't enough.

The Stigma of Mental Illness

Participants described mental illness as stigmatised within their communities, which echoes findings from previous research (Ciftci et al., 2013; Cinnirella & Loewenthal, 1999; Weatherhead & Daiches, 2010; Youssef & Deane, 2006). This was partially attributed to the fact that "people are uneducated about it" (Lameez, Group 2) and that "psychology's very misunderstood" (Sadia, Group 2). When someone in the community did experience mental illness, they would generally be expected to "just get over it" (Fatima, Group 1). For those participants who experienced psychological issues, there was the sense that they were being blamed or judged by those around them:

I didn't tell them I had anxiety issues, they didn't even know like, the extent to which I was an introvert because it's like, 'what's wrong with you?' (Daria, Group 2)

I struggled and a lot of people like in the town were, I don't know, it's like a small community so people were asking me 'what's wrong with you' (Ismail, Group 4)

This tendency is one that has been found in other research in Muslim communities and has been attributed to the view that mental illness betrays a lack of character (Yilmaz & Weiss, 2000) or faith (Schlosser, Ali, Ackerman, & Dewey, 2009) in the individual. This relates to what some participants had to say about how people with mental illnesses are perceived. Daria spoke about how the community would “say ‘no that guy’s crazy’, just you know, ‘he’s not a good person, you shouldn’t associate with him’” (Group 2), indicating a negative moral judgement of the individual.

Participants described their communities as small and “tightknit” (Zakir, Group 1) where “everybody knows everybody else’s story” (Zakir, Group 1). As a result, gossip would quickly spread about problems experienced by members of the community, particularly stigmatised problems such as mental illness. As one participant commented, news would travel fast because of “all the little aunties that sit in the functions that gossip” (Fatima, Group 1). Besides this, an issue such as mental illness would linger in the community’s memory which meant that “stigma... just sticks” (Nurah, Group 3). As Bilqees put it:

...it seems to follow people as well, like you can be over it, seven years on ... do you remember when she... (Group 1)

This caused concern due to potential family embarrassment. Hanaa commented “what will the neighbours say, what will the community say” (Group 2). Along with this was the worry that marriage prospects might be negatively affected: “when you wanna get married what are people gonna say” (Nurah, Group 3). Concern among Muslims about the negative impact of stigma on family status and marriage prospects has been found in previous research (Ciftci et al., 2013; Youssef & Deane, 2006), and places pressure on families to hide mental illness. This was expressed as initial denial as according to Sameena “there’s a lot of denial of mental illness” (Group 4) and Daria commented that “they’re very closed off, they’re like you know what, that doesn’t exist” (Group 2). Where denial failed, different strategies would need to be adopted.

Participants spoke about secrecy as another common approach to dealing with mental illness in their families:

Bilqees: I feel like in Muslim culture, more specifically when you talk about like mental illness, like don't, don't go there

Zakir: Ya, don't go to that topic, don't freak out

Fatima: Don't go there, don't go there (Group 1)

...it gets brushed over, nobody really speaks about it, you know. Even though we know there is an issue, it doesn't get discussed, nothing. (Daria, Group 2)

This made it difficult for those experiencing symptoms of mental illness to speak about what they were going through, both because of their own reluctance to acknowledge what was happening and because of their family's reluctance to do so. When mental illness was acknowledged, families would do their best to keep it out of the gossip rounds by trying to resolve the issue within the immediate family, a strategy that has also been noted in previous research (Ciftci et al., 2013; Youssef & Deane, 2006). The first action many families would take would be to convene a family meeting to discuss the problem:

... my aunt, who went through a depression... the family got together like as a whole and were like you know, we need to do something (Nurah, Group 3)

... in my family they just like, they said let's have a family meeting or something like that and let's talk this through (Ismail, Group 4)

One participant described how the family meeting could in some ways stand as an intervention in and of itself:

...what are you depressed about, let's get closer together, is that maybe the issue, is it an issue of unity (Ayesha, Group 3)

In this case symptoms such as depression were partly construed as resulting from a lack of closeness between the individual and their family. The family meeting reflects the importance of unity and family in the Islamic world view (Ali, Liu, & Humedian, 2004; Ashy, 1999; Basit, 1997) and provides a way for families to both address a problem such as mental illness and to consolidate family unity as a strategy for dealing with it. However difficulties would arise if the problem could not be resolved within the family. Several participants commented on the fact that they saw no issue with seeing a psychologist but Lameez qualified this by adding that "parents ... don't want people outside of their family knowing any issues that they might be dealing with" (Lameez, Group 2). This suggests that even if participants wanted to see a psychologist, their families might put pressure on them to avoid doing so.

Although stigma was mentioned by most participants, variations existed by sub-culture. Participants spoke about differences between Muslims from Indian versus Malay communities, particularly with reference to attitudes towards mental illness:

Warda: I think ...it's very, no I don't think it's very Muslim, it's very Indian

Nurah: Ya like I have coloured [Malay] family, I'm half coloured and half Indian and both of my families sort of a thing of when you're looking for help you go to family first, like my Indian side they more malicious like we'll help you but we gonna talk about it

Warda: Yeah

Nurah: But the coloured side is more of a thing like you can ask me for help and like it will never be mentioned again

Warda: It will, yeah we will help you out (Group 3)

Here Nurah, who is both Indian and Malay, describes the greater tendency towards judgement and gossip on the Indian side of her family, who may be willing to help but at a cost. This is in contrast to Malay attitudes which Bilqees also described as more accepting of mental illness:

I know this one girl ... and she, I think had some kind of mental illness...from this like the cape Malay side, it was very open and no one thought anything bad of her, obviously they prayed for her but it wasn't like this whole stigma that they're speaking about that oh no, it can't be mentioned (Bilqees, Group 1)

This was linked to the idea expressed by Hanaa, an Indian Muslim, that within Indian communities, “feelings are repressed” (Hanaa, Group 2), suggesting that in these communities mental illness is more stigmatised than among Malay Muslims. This in turn feeds the tendency among Indian Muslims to hide signs of mental illness as well as the tendency to gossip. Most of the comments about secrecy around mental illness came from Indian Muslims in the groups whereas participants who identified as Malay were more open and accepting of it. This difference between Indian and Malay attitudes towards mental illness appears to be based on cultural values rather than religious ones. This is supported by

previous research in Eastern counties which found that culture was an important indicator of levels of stigma towards mental illness (Ng, 1997). Despite the fact that Muslims in South African share the same religion, they are still divided along cultural lines. Until the end of Apartheid, Muslims from different subcultures were kept apart. As a result members of different communities would have identified more strongly with their cultural grouping than their religion (Nadvi, 2008; Vahed, 2007). There would also have been little opportunity for different Muslim communities to influence one another's attitudes. While Apartheid might have ended, there are still clear cultural distinctions between Muslim subgroups.

Prayer and the Treatment of Mental Illness

The relationship of prayer to mental illness and its treatment was discussed as two distinct and at times contradictive themes. On the one hand prayer was seen as a source of comfort and a preventative measure against mental illness. This attitude was linked to the view of mental illness as a problem of faith or life choices and is discussed under the sub-theme 'Faith as therapy'. In contrast, prayer was also seen as not enough of an intervention for mental illness when the latter was classified as biological in nature. In these cases outside intervention was considered essential and this is discussed under the sub-theme 'Prayer isn't enough'.

Faith as therapy.

Several participants spoke about the importance of faith in understanding and dealing with psychological issues. The most commonly mentioned manifestation of faith was prayer, which as in previous research (Walpole, McMillan, House, Cottrell, & Mir, 2013) was described as a way of coping with problems and "as a self-comfort" (Fatima, Group 1). When dealing with emotional issues "the whole praying thing it alleviates depression, stress" (Rahma, Group 2) and "when you pray, it kinda calms you down" (Huda, Group 4). Prayer was a strategy that an individual could turn to at any time in order to manage difficult emotional states. This reflects previous research findings that Muslims, more than other religious groups, tend to believe strongly in the benefits of faith related activities such as prayer (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001) and to rely on God when dealing with difficulties in life (Bonab & Koohsar, 2011).

For those participants who shared this view of prayer, faith was an important aspect of their identities as Muslims (Haque, 2004b; Schlosser et al., 2009). Sadia's view was that "Islam covers every facet of being" (Sadia, Group 2) and Zakir commented that "because we are Muslim we associate everything with spiritual wellbeing" (Zakir, Group 1). Faith was

therefore also implicated in the way participants constructed mental illness. For some, mental illness was “your burden to bear” (Ayesha, Group 3) because “God made you that way” (Nurah, Group 3). This, too, reflects previous findings (Springer, Abbott, & Reisbig, 2009; Walpole et al., 2013) in which a certain fatalism can be involved in the interpretation of mental illness: “if you were made that way you shouldn't question it” (Firdose, Group 3). Because faith was central to the ways in which mental health was constructed, its loss was seen as a potential source of mental illness: “a lot of his problems was because he was going away from what religion was saying” (Huda, Group 4). Since deviating from Islam was a potential source of problems, the maintenance of Islamic faith and practices was seen as a preventative strategy:

...if you ... stand up for ...the morning prayer, and you turn to God for help... then if you live your life in that particular way, it will minimise the chances of things going wrong (Sadia , Group 2)

...my faith is my purpose, when everything else fails, that's the only thing that's always there, and so in a way that kind of, is a form of therapy, going towards your faith (Ayesha, Group 3)

Thus, prayer and faith were turned to both for comfort and as a strategy to maintain mental wellbeing. Since in this view mental illness was related to issues around faith, when faced with a problem the approach was “definitely first religion” (Rashida, Group 1) and “always turn to God first before taking a western approach” (Taahira, Group 4). Hanaa suggested that “there are things to heal you in the Quran” (Hanaa, Group 2) and Firdose said “you hear about these amazing stories” (Firdose, Group 3) in which people are healed of mental illness through faith. Religion was therefore the first recourse for some families because of the way faith is intertwined with identity and wellbeing:

...if you're sad, you read the Quran, if you sick, read the Quran, ... we think because we're spiritual creatures and we think that by just praying it will make everything better. (Zakir, Group 1)

Prayer isn't enough.

However in contrast to the existing literature, participants also expressed the view that while prayer was comforting, it was “not really that I believed it's gonna solve my issue” (Fatima, Group 1). In such instances, prayer was seen as more of a supportive measure for dealing

with the normal stresses of life but not as a sufficient intervention for more serious problems: “the serious ones mean medical attention” (Rahma, Group 2). For this group of participants, mental illness tended to be constructed as biological in nature. As Daria said, “prayer alone can't simply help disorders that are genetic” (Group 2). Lameez commented about the difficulty of applying faith to help someone when the issue is about “that person actually having a chemical imbalance within their body cause that is how depression comes about” (Group 2). Mental illness therefore fell within the realm of medicine and as such, medication was considered a more relevant intervention than prayer:

...medication's a big part of it is because people are uneducated about it, they don't see it as being for depression, they don't see it as being a mental illness... so when I say that medication is needed, that it's not only your faith that you can turn to, cause that's, a lot of people expect you to do that. They say ... ask Allah for help and ... they think that will be a cure because they don't understand how depression or other mental illnesses come about or what causes them (Lameez, Group 2)

Here Lameez expresses the view that a lack of understanding about the causes of mental illness is the reason that people suggest faith as a cure and that this will not work for a biological condition which requires medication. Therefore whether or not a condition was considered biological was a vital part of decisions around whether to rely on faith or medicine. These were seen as separate interventions with clear boundaries around areas of relevance: “like obviously when it comes to like a cold or obvious medical things then you go to a doctor but other things like we believe in religion first” (Rashida, Group 1). Psychology occupies an ambiguous space that overlaps to some extent with the biological and the spiritual (Reber, 2006). Participants who constructed mental illness as non-biological therefore tended to lean towards faith as an intervention while those that constructed it as biological leaned towards medicine. This meant that for those taking a biological view, psychological treatment was often associated with medication:

...psychologists give you, if you're depressed, then they give you like anti-depressants (Kulthum, Group 2)

...you could have like a mental illness I suppose and with support of your family, you know, your medications, you could still be happy (Fatima, Group 1)

...in my family I've got quite a few people who have different mental illnesses and we try to make sure they're medicated and that sort of thing (Firdose, Group 3)

As a result prayer was not considered an appropriate intervention. If anything, mental illness had the potential to make prayer either ineffective or altogether impossible:

...in our religion if you are mentally disabled you know you're not going to be required to pray...Allah knows Allah gave that kind of disease and then you're not required to pray ... because you weren't in your proper state of mind (Kulthum, Group 2)

This meant that mental illness, if serious enough, could remove the option of turning to prayer for help since the person might not be mentally fit to do so. In these cases medication was seen as necessary to help the person get to the point of being able to rely on prayer:

...I mean prayer alone, just turning to God alone can't help you because you yourself aren't in your right mind, and you need medication and help and external help to help you through it (Daria, Group 2)

This highlights the idea that prayer is helpful for relatively mild psychological issues, beyond which prayer cannot help and medical intervention is needed instead.

Participants also expressed concern about the fact that reliance on prayer and faith was in a sense encouraging a sense of passivity in the face of problems:

...praying is going to help, definitely, turning to God is definitely going to help but I also need something else, I need something that I can do otherwise I will just feel helpless (Warda , Group 3)

...I feel like you're just giving up your issue, not issue, whatever you're going through, to like a third party like you're not dealing with it (Zainab, Group 1)

There was a sense that prayer might be useful but was not a reason to stop taking the initiative in order to find other solutions, including medication. As Fatima commented “God has given you a brain, please use it” (Group 1) and “don't just accept things blindly” (Group 1). Participants expressed the need to adopt a “God helps those who helps themselves” (Bilqees, Group 1) approach because “Allah says I can give you a certain amount and then you must do the rest, you must put in the effort” (Rahma, Group 2). This was in contrast to

the more fatalistic view that was expressed by other participants, indicating a conflict between the view that prayer and faith were all that was needed for healing and the view that God expects a certain amount of independent effort that may mean doing more than praying.

This sub-theme's divergence from the existing literature can be attributed to a number of factors. The participants were drawn from a university student population and may, among other differences (Henrich, Heine, & Norenzayan, 2010), be more secularised than the samples used in previous research. As noted earlier, Muslims in South Africa differ from those in the United States or the United Kingdom in that they are not recent immigrants and are well integrated into South African society (Quinn & Quinn, 2003). This may have further contributed to their secularisation. Finally, participants were primarily psychology students which may have contributed to their view of mental illness as biological in nature (Reber, 2006), a view that was central to this sub-theme.

The Interaction of Islam and Psychology

An issue that several participants brought up was the degree to which they were able to, or comfortable with, integrating Islam with psychology and medicine. Unlike in western societies, in Islamic societies religion and psychology overlap to a large extent (Skinner, 2010). This was reflected in what some of the participants had to say. Zainab spoke about the fact that she did “take both into consideration but I feel like there should be a balance.” (Group 1). The concept of balance is an important one within Islam and as discussed in the first theme, involves the family and community as well as God (Fonte & Horton-Deutsch, 2005). Participants discussed the presence of two options when approaching mental illness although differed as to whether these should be considered compatible with one another:

Shaazia: You don't know, like a situation might arise and, example if somebody passes away, you could go into depression but you could also seek guidance through Allah and through prayers and all of that, so you could guide the person in a completely western way, and you could guide the person in an Islamic way, I think it depends on the situation itself

Sameena: Why can't you merge it? Cause you can merge Islam and western

Shaazia: You can merge the, ya, but I'm just like being-

Sameena: so why does it have to be binary, why can't you join them together in a holistic approach? (Group 4)

In this excerpt the discussion is around whether Islamic and Western approaches can be combined in treating mental illness. While Shaazia described them as separate options for dealing with depression, Sameena saw them as compatible options to be used in conjunction with one another. Sameena's views reflect previous studies which suggest that Muslims sometimes use Islamic and Western approaches concurrently when dealing with physical or mental illness (Dein & Sembhi, 2001; Walpole et al., 2013). As Bilqees said, when she gets a headache "I'll first try reciting, then I'll try a tablet, or both" (Group 1). This dual approach was described as being in line with Islamic principles around harmony and participants spoke about Islam's openness to other approaches:

Ayesha: ...if you see religion as holistic and inclusive of all, of certain things, or most things then you would be eager, even if you feel like your religion, ya

Warda: It's not only how you view religion but how you view everything else

Ayesha: ya, if you express-

Nurah: It's also a thing of...God wouldn't have put doctors and people here, and psychologists here and given them intelligence and put all this knowledge on this earth if it wasn't meant to be used (Group 3)

This excerpt reveals a potentially inclusive quality to the Islamic world views that allows the maintenance of both God's authority and the freedom to rely on non-Islamic sources of help. Related to this were discussions about the Quran as "a book of guidance" (Zainab, Group 1) as opposed to a book of rules. One that encouraged the seeking of help wherever it was to be found:

The Quran also teaches us that you need to look after your body, it doesn't say how so you can go to a doctor, anything (Rashida, Group 1)

As a result, participants did not have an issue when it came to integrating Islamic and medical approaches, and the same went for combining faith with taking psychiatric medication:

I had a family member who was clinically diagnosed with depression, but she is religious so she'd ... five times Salat [prayer] and all that extra stuff and the Quran and everything, but if she doesn't take her medication then goes to see her,

psychologist or her therapist regularly ... she's depressed, so I think it works together
(Rahma, Group 2)

Medication was seen as falling firmly in the realm of the biological and there appeared to be a well-established acceptance of combining medicine with faith. However therapy was not seen as a biological intervention and as such did not integrate as easily with faith as medication did. As a result, when it came to therapy participants tended to take one of two stances. Some participants were open to seeing a psychologist but did not want religion involved in their therapy at all:

...if I wanted that (religion) I would go and find an Imam (Fatima, Group 1)

...you can go to a person and like speak to them but like you want them to look at you from a psychological point, not like ok you're a Muslim, why on earth are you doing that to start off with (Nurah, Group 3)

I know all my Islamic stuff so I'm not here to get the Islamic side of it cause then I could go to a Imam (Huda, Group 4)

For these participants, religion and therapy were two distinct interventions and each had an area of relevance. If the issue was religious, a religious authority such as an Imam would be consulted, whereas if it was psychological, a psychologist would be consulted. To some extent religious interventions appeared to be associated with “any life decision like is this job for me, is this the direction I want to go” (Bilqees, Group 1) whereas psychologists were associated with having a “really bad problem like depression” (Huda, Group 4). There was little sense of overlap between these two areas and these participants were generally indifferent as to whether their psychologist were a Muslim or not, as long as faith was kept out of it.

Other participants did perceive an overlap between Islam and psychotherapy and they viewed psychologists in a different light. An important concern was around the possibility that a psychologist “might not give you the advice that you need as a Muslim” (Salwah, Group 2). This was an issue related to dealing with a non-Muslim psychologist who might lack knowledge of Islam:

...if it's a Christian psychologist they'll be like get some space, go travel the world or whatever, whereas we know girls can't go travel...alone, stuff like that, now a Muslim

psychologist won't tell you that and then maybe they will know, they'll know you're Muslim and they'll give you advice within the borders of Islam (Kulthum, Group 2)

The worry expressed here is around the idea that a non-Muslim psychologist might not be able to provide guidance which falls within the bounds of Islamic faith and culture. As a result the psychologist could end up guiding their client in a direction which exacerbates the problem or creates new ones. This related to various Islamic rules as well as areas which are considered taboo. However in Group 4 this was a contested view:

Ameen: ... the way we choose to live life and ... like some psychologists would say ok it's fine to drink like a little alcohol cause it's good for you, your health, or they might like say things that against the Quran, and like if you trust their

Taahira: Opinions

Ameen: Opinions, you could be misled...

Shaazia: But then shouldn't you be strong enough in your religion not to be misled?

Nuhaa: Ya, I disagree with that

Ameen: I know but we don't know everything, like you know we don't know everything about Islam, we try our best

Nuhaa: ...most people know the basics of Islam ... if a psychologist knows that you are Muslim or whatever, I don't think they tell you to go against your religion...
(Group 4)

As the extract above illustrates, participants were divided on the subject of whether a non-Muslim psychologist was likely to offer detrimental advice. While Ameen was concerned about that possibility, Shaazia and Nuhaa both disagreed, if for different reasons. Shazia's argument was that a Muslim client bore some responsibility to uphold their beliefs. As in the previous theme, this reflects a rejection of the fatalism that has been linked to the Muslim world view. Nuhaa disagreed in that she saw non-Muslim psychologists as relatively knowledgeable about Islam and capable of tailoring advice to the client's needs. This view was shared by some of the participants in Group 3:

Firdose: I do feel that psychologists, well the few that I've seen are generally quite knowledgeable so they can link it

Warda: So they will be able to link, yeah

Firdose: Ya, they may not know the logistics that, you know the intrinsic details of Islam but they vaguely know what it is so they can make links and-

Warda: and they ... definitely link it sort of to the disability but they don't need to say ok you need to do this, this and this because this is what the Quran says (Group 3)

Here Warda and Firdose discuss the idea that a non-Muslim psychologist may well have enough knowledge of Islam to be able to understand its relevance to issues experienced by a Muslim client. Knowledge of Islam was therefore considered an important guide to understanding what might matter to a Muslim person, but as in previous research (Walpole et al., 2013), participants were divided as to whether a non-Muslim psychologist would have this knowledge.

A common thread throughout the themes, and in keeping with the constructionist framework used, were the different and at times contradictory positions held by participants. Throughout the current theme participants expressed conflicting opinions on the compatibility of Islam and psychology, which were often seen as entirely separate realms that at best could be used side by side. This was in contrast with previous research in South Africa (Ally & Laher, 2008; Laher & Khan, 2011), although it is important to note that previous studies involved counsellors and faith healers as opposed to laypeople. Participants also expressed clear differences in attitudes towards psychiatric medication as opposed to psychotherapy. As in the previous theme, participants distinguished between biological versus non-biological interpretations of mental illness and associated biological causes with medical intervention. There was little conflict around the use of medication, and most participants were comfortable with its use for treating mental disorders whether in combination with faith or not. However participants were less comfortable when it came to psychotherapy based interventions, perhaps due to the perception of psychotherapy as overlapping to some extent with faith based interventions. Medication falls firmly within the realm of the biological, and is therefore not in direct conflict with faith. However, given the overlap between psychology and religion in Islamic culture (Reber, 2006), psychotherapy runs the risk of intruding into areas which relate to faith. This was expressed as the fear that a

non-Muslim psychologist might offer advice which contradicts Islamic beliefs. Yet this did not mean that participants thought Islam should be integrated into psychotherapy.

Participants were clear on the distinction between religion and psychology which were seen as entirely different types of intervention. This reflects a well-established division within Western psychology which in order to become established as a science, was deliberately separated from religion and philosophy (Haque, 2001; Tarakeshwar et al., 2003). As a result psychology is by nature a secular discipline which puts it at odds with the Islamic world view, one that integrates religion into all areas of life. This has led to the suggestion that integrating Islam into psychology may not be possible (Long, 2014). In keeping with this view, several participants were against the integration of Islam into psychology. Even those who perceived an overlap between psychotherapy and Islam thought that rather than changing psychology, it was instead “very important for psychologists today to learn about other cultures” (Daria, Group 2).

Summary and Conclusion

The importance of stigma, faith and the place of Western approaches were core themes in participants’ constructions of mental illness and its treatment. Mental illness was generally stigmatised within participants’ communities which led to different patterns of behaviour at the community and family level. The stigmatised status of mental illness made it a topic of gossip which would rapidly spread through a community causing embarrassment to the affected family. As a result, families tended to initially deny the presence of mental illness in one of its members, and when this failed would turn to secrecy in order to prevent gossip. This led to difficulty for those participants who experienced psychological issues as they found it difficult to ask for help. However the degree of stigma varied between Muslims of Indian versus Malay descent, with Indian Muslim communities experiencing higher levels of stigma and gossip.

Faith was an important aspect of participants’ identities as Muslims although there was considerable variation in the role faith played in mental health as well as the degree of integration between Islam and psychology. For many prayer was a central aspect of faith related practice and was relied on as a coping strategy when dealing with difficult emotions and situations. However, participants also expressed the view that prayer was not enough of an intervention because mental illness was biological in origin and therefore required medical intervention in the form of psychiatric medication. Having access to both faith and psychology, participants found different ways of balancing the two in their approaches to

mental illness. Often they would rely on both concurrently although what differed was the degree of perceived overlap between faith and psycho-medical interventions. Some preferred no overlap and would seek religious help from a religious helper and psychological help from a psychologist. For these participants it was important that religion remain out of the picture when seeing a psychologist. Others did perceive an overlap between the two and worried that a non-Muslim psychologist might not provide the kind of guidance which fell within the bounds of Islam.

A limitation of the study was its sample which consisted of university students studying psychology, which differ from the general population in various ways (Henrich et al., 2010). As a result, participants were likely to be secularised to some extent and more open to psychology than the average Muslim. This means that results may not reflect the views of the typical South African Muslim. However the goal of qualitative research is not generalizability but exploration of a particular issue in depth (Willig, 2008). In addition to this, questions in the focus groups elicited information about the views of participants' families and communities allowing a broader range of perspectives to be explored. Another limitation was the difficulty in finding male participants, of which this study only included four. It is possible that Muslim men may have different attitudes towards mental illness (Khan, 2006). However given the understudied nature of this area of research, the lack of male participants does not detract from the contribution this study is able to make.

The lack of research on the topic of Muslim mental health in South Africa provides a range of opportunities for future research. The current study was limited by its use of a sample of university students. Future research could address this limitation by sampling from a non-university population. Research involving Muslim men would be particularly useful since they are an understudied population in South Africa. Finally, research in other countries indicates that Muslims underuse mental health services, however no research around this issue exists in South Africa. As a result, it is impossible to tell whether the same applies locally. Future research investigating this from a quantitative perspective would also be helpful.

This study has contributed to the limited research involving Muslim communities in South Africa, and has highlighted differences in attitudes between Muslims from Malay versus Indian communities. The degree to which participants saw Islam and psychology as two entirely separate realms was a surprising finding, particularly in light of previous research in South Africa (Ally & Laher, 2008; Laher & Khan, 2011). This suggests that for this group of participants at least, attempts to integrate Islam into psychology would not be

welcomed. However the results also highlighted the fact that some knowledge of Islam is important for a psychologist to understand what might be important to a Muslim client. Therefore when it comes to Muslim clients, this study suggests that the aim perhaps should not be to integrate Islam into psychology, but rather to ensure psychologists learn the basics of Islamic culture.

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PLAGIARISM DECLARATION

PLAGIARISM

This means that you present substantial portions or elements of another's work, ideas or data as your own, even if the original author is cited occasionally. A signed photocopy or other copy of the Declaration below must accompany every piece of work that you hand in.

DECLARATION

1. I know that Plagiarism is wrong. Plagiarism is to use another's work and pretend that it is one's own.
2. I have used the American Psychological Association formatting for citation and referencing. Each significant contribution to, and quotation in, this essay/report/project from the work or works, of other people has been attributed, cited and referenced.
3. This essay/report/project is my own work.
4. I have not allowed, and will not allow anyone to copy my work with the intention of passing it off as his or her own work.

SIGNATURE:

NAME: Alia Gibson

Appendix B



Psychology department
University of Cape Town

Informed consent form

Project title: **Exploring the perception of mental health among South African Muslims**

Researcher: Alia Gibson

Invitation

You are being invited to participate in research aimed at exploring mental health in the Muslim community. I am an honours psychology student at the University of Cape Town and this project forms part of my degree. This project is being formally supervised by a member of the psychology department, and has been approved by the ethics committee.

What will happen?

In this study you will be asked to participate in a focus group of between six and eight students. As a group, you will be asked a series of questions which you will discuss together. There are no right or wrong answers, the aim is simply to explore what everyone thinks about the question being asked. The groups will be recorded using a dictaphone. The groups will run in a room at the psychology department at UCT.

Time commitment

The groups will run for approximately one hour.

Your rights

You may decide to stop being a part of the research study at any time without explanation and without penalty. You have the right to ask that any data you have supplied to that point be withdrawn. You have the right to refuse to answer any question and to have any questions about procedures answered.

Benefits and risks

There are no known benefits or risks for you in this study.

Costs and compensation

There are no monetary costs associated with your participation in this study. You will receive compensation in the form of two SRPP points for participation.

Confidentiality/Anonymity

Your data will be stored securely in a password protected folder on my computer. Pseudonyms will be used at all times, and any identifying information will be removed or changed so as to be unrecognisable. No one other than myself and my supervisor will have access to the recorded sessions, which will be deleted once transcription is complete. Your anonymity will be maintained in any written reports, or in the event of publication of this research.

Further information

If at any time you have any questions and would like further information, you can reach me on aliagibson@gmail.com, or you can reach my supervisor, Wahbie Long, on wahbie.long@uct.ac.za.

Statement of Consent:

I confirm that _____ was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that this participant has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this consent form was made available to the participant.

Signature of Researcher _____ Date: _____

I have read the above information. I have asked any questions I had regarding the research procedure and they have been answered to my satisfaction. I consent to participate in this study.

Signature of Participant _____ Date: _____

Appendix C



Psychology department
University of Cape Town

Audio Recording and Transcription Consent Form

Project title: **Exploring the perception of mental health among South African Muslims**

Researcher: Alia Gibson

This study will involve the use of a recording device during the focus groups. Neither your name nor any of your personal information, will be linked with either the audio recording or the transcript. Only my supervisor and I will have access to the recordings of the focus group sessions.

I will transcribe the recordings myself, and they will be erased once the transcriptions have been checked for accuracy. Transcripts of the focus group may be used in whole or in part in any reports or publications resulting from the research. Your anonymity will be maintained throughout, and neither your name nor any other identifying information will be used in presentations or written products of the research.

By signing this form, I provide consent for the researcher to take audio recordings of this research with the understanding that these will later be transcribed and anonymously used in the products of the research.

Participant's Signature: _____ **Date:** _____

Appendix D

Question list

- What are your thoughts about mental illness?
- How would you or your family go about helping someone with mental illness?
- How – if at all - does your faith relate to your ideas about the causes and treatment of mental illness?
- How helpful do you think a mental health professional would be, particularly a non-Muslim one?
- What sorts of treatment do you think a mental health professional might offer, and what do you think of those treatment options?
- What sort of reasons would mean you or your family might avoid seeing a psychologist or psychiatrist for help?

Appendix E

Ethics committee approval

Reference number: PSY2014-008

Date approved: 27/05/2014