THE RELIGIOUS AND CULTURAL INFLUENCES IN THE DEVELOPMENT OF MENTAL HEALTH PERCEPTIONS IN YOUNG MUSLIM PEOPLE IN THE UK

By

Iman Idjer

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Department of Psychology

Faculty of Health and Life Sciences

University of the West of England, Bristol

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(Bismillahi Rahmanir Rahim).

In the name of Allah, the Most Gracious, the Most Merciful.

The gravity of undertaking a doctorate and working to complete a thesis, particularly its magnitude, intensity, and challenges, often which go amiss, are difficult to explain to those who have not experienced it. However, I have been incredibly lucky to have been surrounded by people who have continuously provided their utmost support.

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ABSTRACT

Understanding the impact of religion and culture on mental health perceptions of young Muslims is important because of the lack of support and access for young Muslims in mental health services. ***Literature:*** The Muslim Youth Helpline (2020) presented a 313% rise in Muslim mental health, especially following Covid-19. Studies that have looked specifically at mental health in Muslims are limited, however the few that are available suggest that Muslims in Western countries did not often use the services provided. It is reported that British Muslims cannot access culturally or religiously sensitive health professionals and are unlikely to seek mental health help in primary care. They have limited awareness on how to get help for their mental health and it is more likely for them to be prescribed medication than referred to therapy; they are also expected to end up in the criminal justice system. ***Methodology:*** qualitative research was implemented for this research, with grounded theory guiding data collection and analysis. Semi-structured interviews were conducted with 10 young Muslims exploring their perceptions of mental health through the lens of religion and culture. ***Results:*** The analysis of data led to one main category: *Navigating Complex Multiplicities* with seven subcategories: *Expectations in Culture, Generational Guilt, Perspectives of Mental Health, Affect, Individual Discovery, Resources in Religion and Connection to Self.* The grounded theory that derived from the analysis of the participants' accounts demonstrates the interactions and processes that young Muslims go through as they develop their mental health perceptions. ***Conclusion:*** The findings of this research provide empirical insight into the processes that young Muslims go through to construct their meaning of mental health difficulties, providing insight into their experience. This research has identified that young Muslims' perception of mental health is impacted by layers of dualities that highlight the way they navigate and negotiate their perceptions. The implication of this research seeks to contribute to understanding for services to facilitate and accommodate for the needs of young Muslims whilst incorporating the varied religious-cultural circumstances to increase the effectiveness of the psychotherapeutic approaches.

TERMINOLOGY

Allah	Allah is the Arabic word that refers to the one and only God in Islam.
Dua	Dua is that Arabic word that refers to a prayer of supplication that is used to request assistance from Allah.
Salaat/ Salah	Salaat is the Arabic word that refers to the prayers that are performed by Muslims that includes cycles of bows and prostrations, with units of prayers, the number of which varies from prayer to prayer.
Qadr	Qadr is the Arabic word that refers to predestination, and is the concept that Allah is the knower of everything and has decided what will happen.
Jinn	Jinn is referred to as spirits or demons that are unseen to humans but can cause physical or mental harm to humans.
Quran	Quran refers to the sacred scripture in Islam and is the holy book that is used by Muslims that was revealed to the Prophet Muhammad (peace be upon him, PBUH) that contains chapters and versus that are revelations from Allah.
Religion	Religion is the belief in, and worship of a God that includes rules and obligations that people observe.
Islam	Islam is a religion that is followed by Muslims who believe in One God, known as Allah and that the Prophet Muhammad (PBUH) is the last messenger.
Muslims	Muslims are the people who follow the religion of Islam.
Religiosity	Religiosity is the conviction and commitment to a religion.
Culture	Culture will be referred to in this research as rituals, traditions and habits of a people that differs from place to place.

CHAPTER 1: INTRODUCTION

All reflective parts of this research are written in first person – the rest is written in third person.

The following chapter seeks to briefly introduce the current research project by highlighting the researchers personal reasons for its conception, and its importance for the field of Counselling Psychology (CP).

1.1 Personal Interest & Development of Research Area

In my personal development group, it was mentioned that this thesis would become a baby of sorts. A baby that we would come to nurture, raise, develop, resent, all in the name of love, desire, purpose. The birth of this research was a culmination of personal experiences that have led me to become increasingly curious about the relationship between religion and culture on mental health (MH).

I grew up in a society where being the only Muslim wearing the Hijab (head covering and dress) was normal, finding myself as the only Muslim in many, if not all, situations. During that time, MH was discussed as a concept that was othered by those around me, and often inconceivable that it would affect me, or those close to me. However, that illusion did not last as I knew I was experiencing my own MH difficulties and had nowhere to speak about it; it went unnoticed. I found myself desperately seeking clarity, observing behaviour, understanding people, to try to identify whether others were struggling too. I often found myself in positions of holding the disclosures of others experiences with MH, as a secret, one that needs to be kept between us. When I went to London for university, I was surrounded by Muslims for the first time, most of my course-mates being Muslim. I often wondered about individual struggle, the sense of duty, the impossibility of self-discovery and awareness, the fear and judgement that would arise in divulging mental struggles and how it is perceived.

At the beginning of this course, I was in the age bracket that this research is based around. Even though I no longer fit the criteria, the curiosity and questions remain the same. In my experience, young Muslims (YM) often find themselves between generations, cultures, religion, and individual sense of self. These aspects interacting together piqued my interest, especially growing up in the UK and living with different ethnic cultures and adhering to British

culture. This is especially interesting as Islamically it is often encouraged for Muslims to fulfil their obligations to the law of the land in which they reside, as mentioned by the Prophet Muhammad (pbuh): "*Muslims are bound by their conditions, except a condition that forbids something permissible or permits something forbidden" (Saheeh Ibn Maajah (2353).* The process of mentalising, balancing, and incorporating all these aspects of the self, felt convoluted, inspiring the ideas behind this research.

I remember when I first came across 'cognitive dissonance', the term that defines the mental discomfort that is experienced by a person when they experience contradictory beliefs and/ or information at the same time (Dawson, 1999). I was at university, and it was one of the first psychological terms that resonated with me as it was a concept that I could apply to the situations I was surrounded by, the people I knew, my personal experiences, and the wider community. Although I personally grew up inclining more towards religious obligations, especially as my household consisted of two strong cultures, so a common ground was found in religion, familial and cultural notions were still present and strongly felt. This also created a dissonance. I observed the way that YM were experiencing a transition, subtle shifts of confidence to detach from cultural expectations, along with the importance that they gave to certain areas of their life. But these were simply observations, I needed to figure out if that was something that existed and was experienced by Muslims or if there was another way to understand what was happening.

The concept of MH, seeking therapy was not spoken about prior to embarking on the doctorate. The medicalised understanding of MH and seeking medication was on the table, however, the option of psychological therapies was not. I remember once talking to a Muslim friend, who whispered in my ear that she went to therapy. I was struck by the experience of shame as I lived in a different world where my relationship with therapy was positive, I would encourage anyone I met to use it, so being faced with not being able to openly talk about it, was striking. Similarly, when I first told some family members that I was going to therapy, there was doubt, concern, and questions around why, as it would be a confirmation that something was severely wrong, which it was. However, the experience and depth of difficulty was minimised. This was challenging as my own perspective of therapy was positive, hopeful, and necessary. This sparked the wider contemplation of the way MH is viewed, the religious

understanding, the cultural perception, and individual perspective towards MH and how they are incorporated into people's lives. This led to the culmination of elements that informed this research. Thus, the proceeding research seeks to understand the way religion and culture impacts the development of MH perceptions in YM.

1.2 What to Expect Next?

The following chapters will include a literature review highlighting the relationship between Islam, culture, and young Muslim people's relationship to MH individually, concluding with a rationale for the research. Then an in-depth methodological section will outline the epistemological positioning of constructivism in the research as well as further exploration of the use of GT as a methodology, qualitative research and what took place in this study. The analysis will then follow with one main theme, and seven subthemes that are explored with evidence from quotes taken from the transcripts. The discussion will look comprehensively at the way religion and culture influence the MH perceptions of YM, the implications of the research clinically and in the field of CP along with the limitations of this research. Reflexivity will also be included along with the conclusion to round up the thesis.

1.3 Chapter Summary

The thesis was introduced from a personal perspective, outlining the reasons for the emergence of this research, and all the elements within it.

CHAPTER 2: LITERATURE REVIEW

This chapter consists of literature relevant to this current research project. The literature review is split into five sections followed by a rationale for why this research is being conducted. The first section is ***Mental Health Perceptions*** which explores the literature that relates to the way MH is perceived and the accessibility to services in the UK. The second section is ***Islamic Perspectives on Mental Health*** that investigates the ways that Islam perceives MH, and the strategies that are in place from a religious perspective. The third section is ***Cultural Perspectives on Mental Health*** where examples are provided for cultural differences regarding MH and the way it is perceived. Next is ***Young People and Mental Health in the UK*** where the experiences of YP are observed concerning MH difficulties and the help available to them. Lastly, the fifth section, ***Young Muslims and Mental Health Perceptions in the UK*** highlights the experiences of YM and their relationship with MH, the stigmata that are experienced and the relevant literature and rationale that determines the need for this research.

2.1 Mental Health Perceptions

Mental health refers to a state of mind that feels safe, able to cope, and a sense of connection to people, communities, and wider environment (Ross & Naylor, 2017). This definition can be implemented and used in various ways depending on the group of people it is applied to and their interpretation of it. The perception of MH of an individual would be their understanding of how they view its impact and importance on their MH; the beliefs and knowledge around mental health and its treatment (Choudhry, Mani, Ming & Khan, 2016). The attitudes and beliefs that an individual holds about MH issues are influenced by personal awareness, interacting with others experiencing MH difficulties and the stereotypes that vary between cultures (Choudhry et al., 2016).

The World Health Organisation (WHO, 2017) views MH disorders as an amalgamation of abnormal emotions, behaviours, thoughts, and interpersonal relationships. Difficulties around MH can result in experiences of distress, jeopardising social interactions and financial stability (Hulsegge et al., 2020). MH difficulties are increasing and is one of the most predominant public health concerns worldwide (Vos et al., 2015). MH problems (such as depression and anxiety)

and behavioural consequences (alcohol, substance misuse and violence) are, statistically, the main influences of disability globally (Lozano et al., 2012). It has been reported that more than 300 million people (4.4% of the world's population) suffer from depression, leading to fatalities such as suicide and ischemic heart disease (Whiteford et al., 2013). It is also projected that 1 in 6 people experience a common MH problem weekly (McManus, Bebbington, Jenkins, Brugha & 2016). The World Health Organisation (WHO, 2017) acknowledged stigma and discrimination towards people with MH difficulties as the biggest barrier to overcome in the community, with advocacy against stigma and discrimination to be one of the main approaches to improving MH, globally.

The provisions for MH care have improved over the years however, there is still a significant amount of people in the United Kingdom (UK) who either do not use the services provided or leave their treatment prematurely (Ciftci, Jones & Corrigan, 2013; NICE., 2019). One of the obstacles that mainstream psychology encounters is modifying therapeutic interventions to provide for the needs of multicultural societies due to its historical efforts to detach from religion and philosophy (Haque & Kamil, 2012). However, it may be useful to observe the ways other cultures approach psychological awareness to be able to incorporate them in the West (Gibson, 2016).

In the UK, it has been calculated that 1 in 4 individuals experience a MH difficulty every year (Health and Social Care Information Centre, 2009). The experience of MH problems has had an impact on the wider healthcare and economy. There have been governmental approaches in the UK to better MH wellbeing and offer an understanding of MH more generally (Department of Health, 2011). The aims of these policies are to encourage individuals to look after their MH, whilst disputing stigmas and unhelpful attitudes (DoH, 2011).

Consequently, people seeking MH help in the UK has been reported to be 12.1% obtaining MH treatment, 10.4% who have been given medication, 3% who have been given psychological intervention and 1.3% who receive medication and therapy (McManus et al., 2016). Approximately 1 in 4 people between the ages of 16 – 74 who have symptoms of MH disorder have been provided some form of MH treatment (McManus et al., 2016). Yet, it is measured that 75% of individuals with MH issues in England do not acquire the treatment they need

(DoH, 2014). Additionally, there are treatment inequalities that exist between different groups of people. It has been recorded that 15% of women receive treatment for all MH conditions, whereas 9% of men get the help they need (Lubian et al., 2016). It was also seen that YP in the UK between the ages of 16-24 were the least likely to get treatment compared to any other age group (Lubian et al., 2016). Lubian et al (2016) recorded that White British people receive 13.3% of MH treatment in comparison to ethnic minority groups (7%). Lubian et al (2016) also documented that the people who receive treatment the least are from black ethnic minority groups (6.2%).

One study in the UK explored ethnic minority service users' experiences in accessing MH care (Islam, Rabiee & Singh, 2015). The results suggested that service users and carers had numerous, opposing, and conflicting explanations of models of illness. For the BME service users, help-seeking includes the support from faith and spiritual healers. The value of proactively involving the individuals religious and spiritual perspectives in therapy is acknowledged, though early intervention professionals are concerned that it may cause delays in treatment (Islam et al., 2015). However, clinicians are aware that they have limited religious, spiritual, or cultural awareness training. Consequently, there isn't sufficient alliance amongst MH services, community and charity institutes that provide for the cultural, religious, and individual needs (Islam et al., 2015).

Refugees and asylum seekers are often marginalised and vulnerable in our society, particularly with regards to accessing MH services in the UK (Burnett & Peel, 2001). Due to socio-economic deprivation and resettlement, there are many acculturation stresses that can impact their MH whilst also requiring the development of cultural competency to provide for their needs (Oppedal, Keles, Cheah & Røysamb, 2020). The complexity of their situation is also because of their personal and institutional migration process which can be a cultural disadvantage (Keating, Roberston & Kotecha, 2003). Refugees consist of various nationalities, ethnicities, cultures, ages and therefore would require different approaches to meet their needs (Bhugra & Bahl, 1999).

One example would be Somali refugees who have faced challenges in accessing MH services in the UK. In a study by Palmer (2006), it was clear that there were powerful socio-economic

factors that played a role in increased stress, such as their status in the country, housing, jobs, and legal difficulties. The individuals that they interviewed all mentioned requiring practical resolutions to their difficulties. It was highlighted that until cultural interpretations of suffering were acknowledged, there would be misdiagnoses, further distancing their ability to access services (Fernando, 2010). This suggests that individuals felt that there was a level of cultural understanding needed to feel confident that appropriate diagnosis and treatment would be given considering cultural reasonings. It was also noted that 'depression' does not exist in the Somali language and 'stress doesn't exist in Somali' (Fernando, 2010). Consequently, facing MH issues is not viewed as a medical problem, but rather a spiritual one, differing in severity. Thus, the most common issues presented in the Somali community in the West has been MH perceptions, cultural ideas, and the limited understanding and treatment for the community (Fernando, 2010).

2.2 Islamic Perspectives on Mental Health

Islam is regarded as a 'complete code of life' by those who adhere to the religion (Awaad et al., 2019). The central belief in Islam is that there is one God – Allah, who is the creator of the world and everything in it, including illnesses (Ahmed, 2004). It is seen to contain guidance for every aspect of human life from financial, social, political, ethical, religious, and cultural understandings (Awaad et al., 2019). It proposes guidelines, standards, and etiquettes for a Muslim to follow, including specifics such as hygiene, how to conduct oneself in relationships, and health and spiritual reclamation which is why it is used and referenced as it promises a happy, successful life (Awaad et al., 2019). In Islam, there are numerous coping mechanisms that provide support from daily hardships to anxiety and other MH conditions (Abdel-Khalek, 2011). This is reinforced in the Noble Quran; 'Those who believed (in the oneness of Allah), and whose heart find rest in the remembrance of Allah: verily, in the remembrance of Allah do hearts find rest" (13:28). Husain (1998) deliberated the physical, psychological, and spiritual impact of the Islamic prayer carried out five times a day. The awareness and attentiveness required in prayer allows the mind to take a break from its current state, providing respite from the pain for the individual. The prayer also includes a physical aspect, altering postures that aids in relaxation, which interestingly are like what present day physicians recommend for lower back pain (Abdel-Khalek, 2011).

Islamic psychology, in Arabic '*ilm al-nafs'* is the science of the *nafs* (self/ psyche), that incorporates an Islamic perspective on the study of the mind (Haque, 2004). There are a few terms that are mentioned by Muslim scholars such as *nafs* which is used to represent an individual's personality and *fitrah* to reference human nature. Within the understandings of *nafs*, the *qalb* (heart), *aql* (intellect), *ruh* (spirit) and *irada* (will) all contribute to wellbeing (Haque, 2014). In the Islamic *ummah* (community) there are safeguards that are given to people with mental illnesses which is fortified by the Quranic reference in *Surah 4:5*: '*And do not give the weak-minded your property, which Allah has made a means of sustenance for you but provide for them with it and clothe them and speak to them words of kindness'* (Sahih International, 2021). This verse condenses the position that Islam takes towards those with mental illnesses, who are unable to manage property, however they must be provided with the best treatment, cared for by a guardian or the government (Youssef, Youssef & Dening, 1996).

Prior to the Western construction of psychology, the Qur'an contained psychological language that explained negative emotions and detrimental conditioning as *nafs al-ammara* or the commanding self. The *nafs* can be compared to Freud's notion of drives (Skinner, 2019). Quranically, it is indicated as the part of the self that is inclined towards worldly desires (Koenig & Al Shohaib, 2019). The Qur'an explains the *nafs* to function out of three conditions: *nafs al-ammara* (commanding self); *nafs al-lawwama* (accusatory self) and *nafs al-mutmainna* (peaceful self). These three states control our psyche, like the later notion described in Freud's psychoanalytic theory as the id, ego, and superego (Samah, 2018). The state of *nafs al ammara* is the notion of the subdued self that is dominated by commands of the mind, such as material gains, and other desires. The *nafs al-lawwama* is influenced by the heart and is aware of weaknesses within the self and encourages a need to perfect. The *nafs al-mutmainna* is the state of peace where the need to chase desires is not overpowering or present (Samah, 2018).

The interaction of these three states is argued to contribute to the health of the mind. When an individual experiences neglect of their basic needs, the *nafs al ammara* starts to govern feelings, thoughts, and behaviours. Consequently, negative thought patterns and habits start to take place, leading down a path of cognitive difficulties that are addressed in the Qur'an with tools to help reduce the power of the *nafs al-ammara* as mentioned above. The conscious

part of our self, *nafs al-lawwama* is then initiated, acknowledging that something does not seem right in behaviour and feelings. These thoughts can be challenged, using similar tools to Cognitive Behavioural Therapy (CBT) which investigates the way thoughts impact behaviour and emotions. Once this is put into effect, it can result in *nafs al-mutmainna* which is the peaceful self (Samah, 2018). The Qur'an provides various chapters and verses specifically to help with various hardships. 'There is no disease that Allah has created, except that He also has created its treatment' (Al-Bukhari, Vol, 7). Thus, the importance of psychological well-being and treatment is strongly highlighted in the Qur'an.

There are numerous ideas that contribute to mental illnesses in the Islamic context, including psychological, environmental, spiritual, supernatural, and biological influences (Ahmed & Amer, 2013). It may be that some mental illnesses have a biological element or could be intensified by environment and circumstances (e.g., poverty). The Qur'an and hadith include many examples emphasising the impact of the environment on MH. For instance, the story of Prophet Joseph (peace be upon him; PBUH), whose older brothers had wished to kill him because of their jealousy towards him. Instead, they took him to a well whereby they left him inside. He was found by a group of travellers who took him to Egypt with them. Prophet Joseph's father, Jacob, became extremely saddened by the loss, his sons having told him that he had been eaten by a wolf. It was narrated in the Qur'an: "*And he turned away from them (the older brothers who related the story) and said, 'O, my sorrow over Joseph', and his eyes became white (he lost his sight) from grief, for he was [of that] a suppressor'* (Qur'an 12:84). This highlights the extent to which situational circumstances can have a mental impact, which also would ring familiar to Muslim patients who would be aware of environmental influences (Ahmed & Amer, 2013).

Moreover, the Qur'an refers to supernatural beings that exist, and mental illnesses are often attributed towards these forces (Warden, 2013). These can be in the form of *wass wass* (whispers), *Sihr* (black magic), *Al- 'Ayn and Hasad* (evil eye and envy) and *Jinn.* Thus, psychiatric issues such as delusions can often be explained through the existence of *jinn* (spirits) which is treated through the extraction method called *Ruqyah* – Islamic exorcism (El-Islam, 2008). As a result of these supernatural forces, Muslims remain aware of the effects that these may have on people (Warden, 2013). Many Muslims in a counselling scenario may assign some of their

difficulties to supernatural influences, despite evidence suggesting other factors at play, such as biology or life circumstances; for instance, marital issues, sicknesses, and other difficulties (Ahmed & Amer, 2013). For example, a study looking at attitudes of Pakistani families on MH found that all their participants' would not consider marrying someone with a MH issue, half would interact with them, and only quarter would think of a close relationship (Ciftci, Jones & Corrigan, 2013).

2.3 Cultural Perspectives on Mental Health

Culture has a reputation for being a challenging concept to define (Spencer-Oatey & Franklin, 2012). Culture will be referred to in this research as rituals, traditions and habits of a people that differs from place to place (Cambridge Dictionary, 2022). When discussing the study of culture, it is often found that religion and ethnicity are closely interwoven (Beyers, 2017). The development of identity is governed by a multitude of factors, so cultural identity is in a constant state of change (Vroom, 1996). Change can be driven through developing identity through belonging to a group and instilling a sense of order, certainty and meaning (Vroom, 1996) along with transgenerational factors that begin in childhood with behaviours, beliefs and practices that are encouraged during childhood (Ho, 2019). Individuals are therefore separated from traditional religious beliefs to adopt 'cultural-religious' identities that do not always comprise of religious material (Beyers, 2017). Cultural perspectives also influence their perception, help-seeking behaviours, attitudes, and behaviour regarding MH (Palmer, 2006).

One study explored opinions on MH treatments in Switzerland, revealing 18 options of help available, including psychologist, psychiatrists, general practitioners that were helpful for some disorders (Lauber, Nordt, Falcato & Roessler, 2001). In contrast, MH difficulties were not widely recognised by the public or accepted in Pakistan with stigma accompanying being seen as mentally unwell (Suhail, 2005). Often, it is religious leaders who are sought out first to deal with MH issues as it is perceived to have a supernatural influence (Mubbashar & Saeed, 2001). The cultural perspective is essential when exploring perceptions around MH, as the interpretation differs between cultures (Choudhry, Mani, Ming & Khan, 2016), in turn influencing whether individuals chose to seek support (Dow, 2011). For instance, it was seen that upon receiving a diagnosis, individuals no longer contacted services despite a therapeutic need (Tehrani, Krussel & Borg, 1996). This was due to several factors such as attitudes towards

treatment, 'subjective norm' which relates to a persons internalised social pressure to engage with a behaviour, family's willingness to assist the relative and the long-standing effects of stigma attached to a mental illness (Corrigan & Wassel, 2008). Additionally, a population of southeast Asians observed that supernatural occurrences are liable for MH issues, resulting from rejecting the existence of spirits or divinities (Khan, Hassali, Tahir & Khan, 2011).

The studies that explored MH perceptions have demonstrated a variety of outlooks and understandings of how mental illnesses develop and the treatment processes that are adhered to. Studies in Asia demonstrated the idea that physical ailments impact emotional issues, resulting in seeking physical treatments and remedies (Naeem, Ayub, Kingdon & Gobi, 2012). Chinese culture explains issues in MH through celestial forces that are managed through exercise, diet, and relationships (Zane, Takeuchi & Young, 1994) which has also been found in studies conducted in Nigeria (Adebowale & Ogunlesi, 1999). Generally, the West has laid the foundations of MH across the globe through their services, considering the traumas, societal influences and history of individuals experiencing MH issues (Satcher, 2001).

Similarly, a study carried out in Malaysia looked at the views of Muslim Malays and MH and found that more than half (53% out of 134 participants') conveyed that their illness as due to witchcraft and evil spirits (Razali, Khan & Hasanah, 2008). They also believe in a more cultural notion of 'semangat' which is a soul-like element that could be lost resulting in confusion, however it hints towards the idea that MH issues are a consequence of abandoning religion and not following the practices and values (Haque, 2005). An additional cultural belief is that Malays argue that gas in the stomach and blood vessels have an impact and can result in hallucinations and delusions (Haque, 2005).

It has been related that western populations have a general understanding of what may cause mental disorders, whilst also acquiring enough information about available treatments. Nonetheless, in the West, building an understanding of the various cultural beliefs of Muslims from different countries of origin could be helpful for a clinician. For instance, Arabs often attribute MH issues to situations outside of themselves as opposed to the involvement of biology in the process. This may be influenced by other people and *jinn* through evil eye or black magic (Al-Krenawi & Graham, 2000). A study conducted by Al-Habeeb (2004) investigated

45 faith healers in Saudi Arabia who ascribed psychological issues to be because of supernatural forces, identifying symptoms such as obsessions, anxiety, doubt, insomnia, depression, distorted consciousness, and somatic issues (Al-Habeeb, 2004). These beliefs have been found to influence attitudes around seeking help for MH issues, particularly because of societal stigma which is still largely negative (Aloud & Rathur, 2009).

Muslims worldwide consist of a diverse range of cultures which differ accordingly in their views and treatment of MH. Although the biological and psychological ideas of MH have developed, particularly in recent times, the awareness of the existence of supernatural forces remain as a possibility (Ahmed & Amer, 2013). These notions have decreased in Western countries whereby acculturation has been more prominent (Ismail, Wright, Rhodes, Small & Jacoby, 2005). For instance, there has been an increase in the acknowledgement of life events as a reason for mental illness, such as an increase in stressful events (Weatherhead and Daiches, 2010). However, it remains that supernatural forces still hold a significant impact in a Muslims perception of MH despite other Qur'anic and Western explanations (Abu-Ras, Gheith & Cournos, 2008).

2.4 Young People & Mental Health in the UK

Mental health is increasingly becoming an issue for YP with several studies demonstrating a decline in well-being. Rees (2020) found that women between the ages of 20 to 24 in the UK reported low life satisfaction, happiness and high anxiety compared to five years prior. Also, anxiety and depression were recorded at 31% in those aged 16 to 24 in the UK, which is a 5% increase from the previous year (Rees, 2020). There has been a rise of YP aged 16-24 who are faced with financial difficulties and feelings of disconnection from their communities (Gromada, Rees & Chzhen, 2020). The MH foundation (MHF, 2021) notes that 50% of MH problems are identified at the age of 14 with 75% being identified by the age of 24 (Kessler, et al., 2005).

The beginnings of MH issues are most prevalent in adolescence and early adulthood (Kessler et al., 2005) whereas the onset of physical illness tends to be later in life. Early adulthood is a significant time for various reasons such as being a transitional period from adolescence to adulthood, gaining responsibility and independence (Hoffman, 2002). YP's MH is a great

concern, with most diagnosable MH issues occurring between the ages of 12-25 in the UK (Royal College of Psychiatrists, 2010). Although there is an acknowledgement in policies (NHS England, 2016), there is still a low number of YP utilising primary MH services in the UK (Bunglawala, Meha & Tunariu, 2021; Issakidis & Andrews, 2006). Literature conclusions on causes include self-reliance (Salaheddin & Mason, 2016), negative attitudes and experiences towards obtaining services (Rickwood, Deane & Wilson, 2007) and stigma (Schnyder, Panczak, Groth & Shultze-Lutter, 2017).

There is significant evidence that shows that interventions at earlier stages can have a positive effect on individuals (Patel, et al., 2007; Colizzi, Lasalvia & Ruggeri, 2020). However, there are very few young adults who get help early on, usually averaging about 10 years after the first experience of MH difficulties to access help (Kessler, et al., 2005). This demonstrates some major overlooked opportunities to alter the course of MH outcomes and help the life chances of vulnerable YP in the UK. The child and adolescent MH service (CAMHS) and the adult MH services (AMHS) are available for minority groups that are heavily regulated, specifically for those with complex disorders (Hill, Wilde & Tickle, 2019). Therefore, there is a problem in the provisions for YP to access help where needed. Whilst CAMHS has attempted to fill the gap through making connections to the lower ranges of the adult system, this hasn't been completely successful. This was demonstrated by Singh and colleagues (2010) who argued that services for young adults contribute to the increase in gaps due to the incomplete handovers from adolescent to adult systems. Other systemic issues were also identified such as space, staffing and waiting lists (Glowacki et al., 2022) Consequently, YP can miss out on support that would be helpful during a time where they face difficulty in their wellbeing and needing the most help (McGorry et al., 2013). This is further problematic as the gaps occur at a time in YP's lives where they are less likely to be actively seeking help from services for themselves (McGorry et al., 2013).

There are studies exploring YP's beliefs and opinions about emotional and mental well-being (Gordon & Grand, 1997) yet, they have not primarily looked at mental distress. YP's perspectives on MH problems are important for the development of future beliefs and attitudes (Charles & Felton, 2020) as it has been shown that their MH experiences are an internalised phenomenon, which is situated in the background, often viewed as a hidden part

of who they are (Charles & Felton, 2020). Some explanations for this could be due to dependence on self to resolve difficulties (Rickwood, Dean & Wilson, 2007), earlier unhelpful experiences in services (Ford, Hamilton, Goodman & Meltzer, 2005) and shame (Schnyder, Panczak, Groth & Schultze-Lutter, 2017). There has been MH research that has attempted to discover ways of reaching YP, leading to the implementation of visual techniques that have enhanced participation of YP in MH research (Kloos & Shah, 2009; Miller & Happell, 2009). The visuals are used to engage with their emotions, provide alternatives to verbal communication (Sibeoni, 2017) and evoke the identification of what is being embodied within – such as emotions and sense of self (Brown, Reavey, Cromby, Harper & Johnson, 2008). Thus, through the exploration and understanding of YP's MH perception, their needs can be identified to support the prevention of the pervasiveness of stigma, the risks of seclusion and social exclusion.

2.5 Young Muslims & Mental Health Perceptions in the UK

The largest non-Christian faith in the UK is Islam, with 3.3 million British Muslims, 48% being aged 24 or younger, in comparison to 31% of the general population (Census, 2021). Research conducted has had a particular focus on ethnicity, as opposed to religious identity. An example of this would be 'South Asians' which would refer to Muslims, Christians, Hindus, Sikh etc (Musbahi, Khan, Welsh, Ghouri, & Durrani, 2022). Although Muslims may have a cultural similarity with other religions in the same ethnic group, there are some disparities that differentiate Muslims from other faith groups. There are numerous limitations within ethnicity-focussed literature including those that do not differentiate between migrants and those who are second-and third generation (Bhui et al., 2007; Weatherhead & Daiches, 2010). There is also a concern that significant differences within an ethnically diverse community can be managed in a standardised way, assuming that one approach is suitable for all when factoring in treatments, interventions, and support from services (Borrill et al., 2011; Mir & Sheikh, 2010).

Although studies that have specifically looked at MH in Muslims are limited (Abu-Raiya & Pargament, 2011), the few that are available suggest that Muslims who reside in the West did not often use the MH services provided (Weatherhead & Daiches, 2010). It is reported by Walpole and colleagues (2013) that British Muslims cannot access culturally or religiously

sensitive health professionals and so are unlikely to seek MH help in primary care. This also means that they are expected to end up in the criminal justice system in a calamity; have limited awareness of ways to gain MH help, whilst maintaining a different outlook on MH; and they are more unlikely to be referred to therapy whilst more common to be medicated (Bignall et al., 2019).

There is a small amount of information that provides statistical evidence for the experiences of Muslim YP. However, a report was conducted by the Better Community Business Network (BCBN, 2019) that looked at the untold stories of many segments of life, such as private, communal, familial, parental, religious groups, faith leaders, the public, statutory services, MH practitioners and broader society that impact the MH of YM in the UK. From this, there was a call to increase awareness of MH issues faced by Muslim YP along with the need for access to cultural and faith appropriate MH services or resources which is paramount. The report notes that YP who experience MH struggles have sought help from friends (52%), then family (30%) therapy (20%) with 1 in 5 (18%) not turning to anyone. The importance of MH understanding is crucial when it comes to support and signposting, as well as referring for help. Faith has a positive role in supporting mental wellbeing amongst Muslims (59%), and amongst the participants' (81%) that experienced MH struggles. Over half of the YM men turn to faith when they are experiencing MH difficulties (61%) compared to YM women (56%). Moreover, approximately three in five YM (61%) say it's important for MH services to accommodate for culture and faith. A higher importance placed on faith and cultural sensitivities was found in individuals who had received previous counselling (90%) who mentioned that it was essential (Bunglawala, Meha & Tunariu, 2021).

There is an increasing body of research that has been looking at the way British Muslim youth are facing similar difficulties to non-Muslim adolescents with the addition of dealing with issues surrounding being Muslim in a non-Muslim society (Hamid, 2011). There have been movements to encourage the provisions in schools for halal food, wearing the hijab, not engaging in Christian prayers since the early 80's due to the arrival of more people from the Islamic faith (Lewis, 1994). It was later noted by Lewis (1994) that religion was operated in families to transfer their cultural values onto their offspring, particularly when acculturating to a new society. Nevertheless, British-born Muslims questioned the cultural practices that were

expected of them, leading to a shift of focus, from ethnicity to religion in the way they developed their identity (Geaves, 2010, p. 301). This led to a transition, whereby there was an increase in religiosity amongst young British Muslims (Lewis, 2008; Gilliat-Ray, 2010), or there were 'cultural Muslims' who did not regularly practice their faith (Ramadan, 2010).

Musbahi and colleagues (2022) conducted a study that demonstrated a difference in stigma between Muslim and non-Muslim YP, especially due to the largely negative emphasis on Islam and Muslims in the previous generation (Kidd & Jamieson, 2011). There was a difference in attitude towards MH between YM, compared to young non-Muslim people. It was shown that MH was seen as one of the most upsetting illnesses to experience, overriding experiences of chronic and terminal conditions. Explanations for this could be the observance of another psychological model of MH, along with young British Muslims attempting to develop an understanding of their own religious and cultural identity due to being raised in the UK (Prajapati & Liebling, 2021; Rothman & Coyle, 2018). Furthermore, it was highlighted that YM had a harder time recognising symptoms of mental difficulties than fellow non-Muslims. This reveals a need for religiously sensitive modifications to mainstream MH therapies which has encouraging impact for Muslim service users (Cook, 2018; Mir et al., 2015).

Geaves (2010) explained that there is a mergence between ethnicity, religion, and cultures where there are three tensions: *Ethnic Culture, Qur'anic Islam, and British Culture*. Geaves (2010) argues that first-generation Muslims used religion as an identity marker that allowed them to build a community whilst playing a part in 'micro-politics'. The second-generation would then become more involved in British culture and society which created a tautness, particularly with religious scripture in the midst that provided written and evidence-based reference that allowed the bypass of culture. This meant that an observance of the main foundations of Islam through the Qur'an and Hadith are referred to as a point of reference over culturally influenced understandings (Geaves, 2010). This allowed the younger Muslims to have the option to implement the Qur'anic text that allowed the separation from cultural expectation, whilst other YM were able to integrate the religious, ethnic, and secular standards in a way that suited them better (Geaves, 2010). The interaction of each of these elements may have a fundamental impact on the MH perceptions developed by YM.

The role of religion and culture amongst British Pakistanis has recognised a range of identities, from individuals devoted to their faith to those who identify as being cultural but not practicing Muslims (Hamid, 2011). An interplay was identified by Jacobson (1998) of prescribed practice, routine, mannerisms, and attitudes that make up the conduct of a Muslim. The notion of 'hybridised' identities has been put forward by Ali and colleagues (2006). The Muslim Youth Helpline (MYH) report by Malik and colleagues (2007) mentioned that the main concerns that impacted Muslim youth was relationships, MH, religion, criminal rehabilitation and offending, sexuality, and sexual health. The difficulty of finding services that catered to the dual identities of being British and Muslim was lacking particularly regarding the inclusion of all the external socio-economic issues, such as concentrated Muslim communities in inner city 'deprived' areas with high levels of unemployment, ill health, poor housing, and crime (Malik, Shaikh & Suleyman, 2007) that presented alongside their initial concerns (Fekete, 2009).

There is a rising acknowledgement that faith has a considerable influence on beliefs, perceptions, and attitudes for individuals which can be an affirmative influence on their life (Borrill et al., 2011; Jacobson, 1997). It was promoted by Dein and colleagues that there is a requirement for research to investigate the difference between culture and religion, and individuals belonging to various backgrounds (Dein, 2004; 2012; Dein & Illaiee, 2013). However, for Muslims, the use of Islamic practice such as prayer, recitation of the Quran and fasting, as coping mechanisms for adversities in life has been recognised as the main reason why MH services are not sought (Loewenthal & Cinnirella, 1999). Other reasons include MH stigma and the stereotypes that exist in society (Ciftci, Jones & Corrigan, 2013). This suggests that there is a gap in mainstream psychology that falls short of meeting the MH needs of Muslims.

Although national healthcare policies advocate for professionals to consider cultural identities to ensure suitable provisions for minority religious groups, there is limited understanding in how to do this, and a lack of research evidence that demonstrates ways to meet the needs of these faith groups (Meer, Mir & Serafin, 2012). Treatment in the context of this research includes a care plan that is in support of someone facing difficulties that seeks to work within the boundaries of the individual's religion, or culture. This is to provide applicable and appropriate help for the service user, acknowledging specific and intricate challenges that may

differ from the mainstream Western ideas, which might deter individuals from further seeking help (Haroun et al., 2011). The challenges that are faced by this group is increasing, especially for those who suffer with low levels of mental well-being. This has been further highlighted in recent events such as the Covid-19 pandemic that has stormed through Britain's ethnic minority communities with elevated death rates and the impact it has had on British Muslims. The disregard of ethnicity and religion in policy discourse and practice is under examination (Bunglawala, Meha & Tunariu, 2021). Since March 2020, a national helpline in the UK, Muslim Youth Hotline, that provides confidential faith and culturally sensitive support for YP, recorded a staggering 313% surge in calls relating to MH.

Psychology in Islam maintains a holistic outlook of an individual, considering the involvement of the mind, body, soul, and self (Haque, 2004a). A dissonance occurs when a conflict arises between these entities, resulting in the individual experiencing an illness that manifests physically or psychologically (Skinner, 2010). Consequently, the care received could be an intervention that is physical, psychological or both (Ally & Laher, 2008) depending on the individuals' needs. It could be noted that the way in which MH is portrayed or felt by an individual could be impacted by faith, as it is seen as a powerful healer that can aid recovery (Youssef & Deane, 2006). It has been shown that MH issues could be seen as a test for an individual from God (Abu-Ras, Gheith & Cournos, 2008). Muslims' have a belief in *Qadr* – predestiny, which has been found to increase positivity and hopefulness in God when it comes to recovery (Hasnain, Shaikh & Shanawani, 2008). Padela and colleagues (2012) found that some Muslims may find being faced with an illness as a prospect for reconnecting to God (i.e., Allah) by engaging in religious acts such as prayer.

There are numerous ways of understanding MH issues between cultures influencing the way in which treatment is sought. The Western culture is largely secular which informs the psychological practice, particularly due to the historical relationship between religion and psychology (Tarakeshwar, Stanton & Pargament, 2003). Psychology has worked to achieve scientific grounds that are independent from philosophical ties, and consequently religion (Haque, 2001). Despite the averseness to involve religion into treatment, Islam is a religion that is heavily integrated into the life of a Muslim, shaping the client's views of MH (Tarakeshwar, et al., 2003). Therefore, in the treatment process, a lack of understanding of Islam, its values,

and philosophies could prevent effective interventions for the client (Cinnirella & Loewenthal, 1999), which may elucidate any hesitancy Muslims have when seeking psychological support. Prayer has shown to have a positive impact on individuals who experience difficulties like anxiety and depression (Abdullah, Ismail, Ahmad & Hissan, 2012). *Salah* (prayer) in Islam is an act of putting total dependency on, and submission to Allah, whilst making supplications to be granted relief from difficulties (Sayeed, Prakash, 2013). Studies have demonstrated that non-Muslim participants' simply engaging in the physical movements of *salah* provided noticeable positive outcomes from the exercise (Doufesh, Faisal, Lim & Ibrahim, 2012).

2.6 Research Rationale

The literature review highlights that although religion can be conceptualised as a culture due to a set of belief systems and practices that can vary amongst traditions, religion specifically attends to the relationship with the Creator (God) and faith (Cohen, 2009. This research addresses the religion of Islam to be an overarching belief system that adheres to the 'submission to the will of God', whose followers are known as Muslim, who believe in one God, Allah, and the teachings of the Prophet Muhammad. Within the religion of Islam, there are cultures that exist across nations that can experience, understand, and process religion differently (Kitayama, 2002) and provide the framework where religion is situated. This research distinguishes between religion and culture and recognises that they are not the same, but that they can be interrelated for many people. There are also overlapping concepts that exist within religion and culture but the connotations around them can differ, such as the beliefs that are held, how religion is practised, and the way certain religious principles are thought about (Croucher et al., 2017). For instance, the notion of spiritual possession can exist within Islam and numerous cultures across the globe; however, this can differ in the way that it is considered and implemented. This can be difficult for people to distinguish between because of the complexity of experience for individuals and the sense of entanglement between religion and culture despite being very much separate concepts (Sasaki & Kim, 2011).

Additionally, the review identified a gap in the literature for YM living in the UK and their perceptions and conceptualisations around MH issues. The layers of identity that come with being a young Muslim, in a non-Muslim country, is an area of research that needs more exploration (Haroun et al., 2011). This is especially relevant as there has been adverse and

negative attention post the 9/11 climate towards Islam and Muslims, which continued during the upbringing of these YM (Bonino, 2019; Tanhan & Young, 2022). This raises the importance of observing MH perspectives in YM as it can also be stigmatising to them (Musbahi et al., 2022). YP's perspectives on MH problems are important in the development of future beliefs and attitudes as it has been shown that their MH experiences are an internalised phenomenon, which is situated in the background, often viewed as a hidden part of who they are (Charles & Felton, 2020). Previous literature has commonly researched MH and culture through the context of ethnicity, nationality, and race. However, more recent literature surrounding the mental health of Muslims implies religiosity being significant as Islam can shape how emotional distress is understood, communicated, how relationships are formed as well as MH help seeking behaviours in the Muslim community (Altalib et al., 2019; Padela et al., 2012). There are numerous ways in which mental health may be perceived by Muslims, nonetheless, YM' experience may differ under the influence of cultural and religious factors of their families, whilst adopting and maintaining Western ideologies. By exploring young Muslim's perception of MH in the UK, this research can inform available services and implementation of interventions and how it can be readily accessed by YM.

Understanding how MH perceptions are developed in YM may provide important insights for developing effective formulations and interventions for them. This may contribute to MH professions, inform practice in, and enhance practitioners' cultural competency. Promoting such an inclusive environment in clinical practice will hopefully encourage help-seeking behaviours. Some of the barriers that contribute to the needs of this population not being met include marginalization, stigma, discrimination, racism, difficulties around assimilation (Amri & Bemak, 2013; Ali, McLachlan, Kanwar & Randhawa, 2017) along with a disproportionately low representation of Muslims in the MH field (Ragavan, 2018). These barriers advocate a need for accessible MH services for this minority group in the UK. Furthermore, this research can increase awareness and understanding of cultural and religious beliefs so that more consideration can be given on how these can be incorporated in the therapeutic work with YM (Amri & Bemak, 2013).

2.6.1 Implications of this research

Recent guidelines for practice (BPS, 2022; HCPC, 2021) further discuss the issue of diversity in psychology and therapy, resulting in a greater need for a deeper understanding of how culture and religion affect therapy and inclusion. This is particularly relevant for the implications in CP as to inform reflective practices in considering ways of working with YM and gaining further insight into understanding their experience. This research is in alliance with the principles of CP which acknowledges and appreciates the importance of supporting mental well-being (Hameed et al., 2010), especially when considering the deeper and wider contexts being experienced when working with clients' belief systems in person-centred care (Morgan, 2017). This includes holistically understanding all parts of an individual's life, to facilitate and advocate for their needs, particularly as CP welcomes integrative approaches in research and practice to promote innovative and inclusive interventions (Kasket, 2017; Jones & Moffitt, 2016).

Furthermore, in the CP field, there has been encouragement to continue to promote social justice to allow equal and just provisions, encouraging involvement from all groups of people (DeBlaere et al., 2019; BPS, 2005; Cutts; 2013). The present research aims to contribute to the field of CP by exploring the development of MH perceptions in YM in the UK. This is due to the lack of representation and research for this group (Tanhan & Young, 2022; Hovish, 2012), and the lack of access to help and support that they receive illustrated by the Muslim Youth Hotline (2020). This research hopes to utilise GT to broaden perspectives of how MH perceptions are developed in YM which can contribute to healthcare professionals attending to their needs. The proposed research aims to use qualitative methodology to have an in-depth exploration of the way in which YM conceptualise their understanding of MH to observe whether this understanding can be used to enrich provision for YM' welfare. Consequently, the findings could enhance the awareness and knowledge concerned with this population, along with influencing policies, practices, and interventions.

2.7 Chapter Summary

This chapter includes a summary of the relevant literature for this research. It is comprised of five sections that are pertinent to the elements that make up this research. The first section looks at what defines MH perceptions and the importance of acknowledging some of the barriers and challenges in MH. The second section explores Islamic perspectives on MH,

providing an insight into the ways in which MH is referenced in the religion. The next section looks at cultural perspectives of MH, highlighting differences in how MH is seen by different societies, impacting help-seeking behaviours. The fourth section provides insight into YP and MH in the UK, demonstrating the prevalence of MH is prevalent in YP and the availability of interventions. Lastly, the fifth section looks at YM and MH perceptions in the UK, providing evidence to the limited research that observes this group of people, whilst also highlighting a need to provide culturally and religious sensitive interventions. The findings from the literature have shown a lack of research that explores the experiences of young Muslim people's perceptions of MH in the UK, which is what this study aims to explore. This chapter therefore recognises a gap in the research which defends the need for this study.

CHAPTER 3: METHODOLOGY

This chapter presents the research design and methodology that was implemented in this study and the influence that this has had on data collection, analysis, and the growth of theory. I will begin with outlining my epistemological position as the researcher, then I will define the methodology used, along with discussing the recruitment process, data collection, data analysis that were conducted. I will also include the ethical considerations that went into this research.

The aim of this research was to explore the specific characteristics of the processes with which religion and culture influence the development of MH perceptions in young Muslim people in the UK. To gain an understanding of these processes for the participants', the research question of the current study is: ***What are the cultural and religious influences that impact the development of mental health perceptions in Muslim young people?*** The research objectives are:

- To contribute to and build upon existing research and theory to see how culture and religion impacts the development of mental health perceptions of young Muslim people.
- To investigate the ways in which young Muslim people formulate their well-being around culture and religion.
- To identify whether religious identity, values and behaviour affect beliefs regarding mental health perceptions.

The method that was used for this research question was a qualitative design as it was deemed the most suitable for gaining insight into participant perspectives (Silverman, 2020). Qualitative research seeks to engage in questions that aim to understand the multitude of meanings, experiences that exist in the lives of people and in social contexts (Fossey, Harvey, McDermott & Davidson, 2002). For this research, qualitative methodology was implemented to answer the research question through implementing semi-structured interviews that were conducted with YM people, exploring their perceptions and their development. GT was used to guide data collection and analysis (Charmaz, 2014). The stages will be explored in more detail below.

3.1 Epistemological Positioning/ Philosophical Perspective

The epistemological and ontological position as they were conceptualised and applied for this research will be outlined below. Epistemology is described as the way in which people attain knowledge, considering the various psychological paths to knowledge, including processes of reasoning, introspection, perception, memory, testimony, and intuition (Martinich & Stroll, 2021). In simple terms, epistemology answers the question "how do I know what is true?' (McDowell & Sharp, 1999, p.75) whilst devising a way of observing how individuals understand and observe their world. Ontology is defined as 'what exists in the human world that we can acquire knowledge about?' (Moon & Blackman, 2014). Ontology can aid researchers in identifying how assured they are about the nature and existence of what they are researching (Moon & Blackman, 2014, p. 1170). In other words, ontology tries to uncover what is meant when we say something exists. Ponterotto (2005) defined philosophical perspectives within science to include ontology as the 'nature of reality and being' (p.g. 127) and epistemology as the attainment of knowledge.

It is important to acknowledge that there are numerous ways in which qualitative researchers may approach their research, differing in their epistemological assumptions (Denzin & Lincoln, 2008). Although there are some adaptabilities in choosing a method to implement, the epistemological and ontological commitments of the researcher compel the acquisition of a specific method. The relationship between epistemology, methodology and data collection is influenced by the way epistemology directs and is warranted through the information that is being formed (Carter and Little, 2007). Following this, data collection and data analysis conducted within the epistemological position, lead to constructing knowledge.

The epistemology that informs the present study is social constructivism which places importance on what is being explored and understands the data and analysis from the perspective that is shaped by shared experiences and researcher's interactions with participants' and other factors (Bryant & Charmaz, 2007). According to Bryant and Charmaz (2007, p.239), 'constructivists study *how* – and sometimes *why* – participants' construct meanings and actions in specific situations'. Interpretation is key into how constructivism theorises research data (Bryant, 2002; Charmaz, 200, 2002, 2008, 2014).

The methodology used for this research is constructivist GT which is contingent on the researcher's perspective (Clarke & Charmaz, 2014). This is due to the researcher co-constructing meaning with the participants' of what is being studied (Charmaz, 2014, 342). Clarke (2014) developed this idea, with the outlook that the reality of the research involves who and what is in a situation, the impact of the wider environment that it exists in and to what degree the experience being observed is rooted in bigger and more hidden circumstances. Therefore, the constructivist approach is seen as being aware of the conditions in which differences and distinctions appear and are preserved.

The methodology is employed to construct knowledge from participants' experiences. The data is gathered and analysed using repeated comparison to inform and enhance data analysis process (Watling & Lingard, 2012). The constructivist GT posits that the researcher is an essential part of the process. By understanding the impact of the researcher, in terms of conducting memos and reflexivity, data analysis and interpretations are more grounded on the data (Charmaz, 2006). The purpose of implementing a constructivist analysis involves understanding the participants' meanings, which are naturally interpretations and construct a theory (Charmaz, 2006) or working hypothesis (Lincoln & Guba, 1985). Therefore, constructivist GT is fitting for this research as it allowed the exploration of participants' numerous realities about the way in which religion and culture influence the development of their MH perceptions.

It was further acknowledged that there are epistemological approaches such as critical realist that can explore a phenomenon through the perspective that an objective reality exists as well as the subjective perspectives of that reality which could be more in line with religious beliefs. However, social constructivism was chosen as the epistemological lens as the researcher and participants' co-construct meaning through the data collection and analysis which recognises the reciprocity in the relationship (Morrow & Smith, 2000). This suits this research as it supports the process of providing insight into an individual and the shared process that occurs between the participant and the researcher. This also fits in the counselling psychology model of sitting in a room with a client and co-creating meaning by utilising a relational approach and recognising that what the client brings is often an interpretation of their experiences outside of the room (Gunzenhauser, 2006). The relational approach is a way of interacting with the

participants' that promotes active listening, rapport building, respect, honesty, compassion, empathy, and considers the aspects of the relationship that can influence the participants' level of comfortability, openness, and response. Consequently, the epistemological approach was selected on its relational capacity that was useful for informing the data collection and analysis in this research.

3.2 Research Method

Research method has been described as the process of investigation that moves away from 'the underlying philosophical assumption to the research design and data collection' (Myers and Avison, 2002, p.7). The reasons the methodology and approach were chosen, along with the limitations for the chosen approaches will be explored further below.

Qualitative research has been used extensively in social sciences which seeks to speak to questions that involve subjective meanings and social contexts of participants' (Flick, 2004; Fossey, Harvey, McDermott & Davidson, 2002). Researchers who use qualitative research are curious about understanding the way people construct meaning for themselves, the world, and the experiences they have within that (Worthington, 2013). Qualitative research adopts the notion of conceptualisation of meaning inter-subjectively through a collective understanding that can stem from a philosophical or emotional base which contributes to the meaning making of the community they reside in (Nerlich, 2004).

It has been mentioned that qualitative methodology is connected to constructivism as it acknowledges and accepts the investigation of subjective experiences (Charmaz, 2000). Through the exploration of subjective experiences, it is recognised that there are a diverse variety of emotions, perceptions and thoughts that can be included. These elements provide an insight into the meaning making processes of subjective experience and its analysis. This can be done through exploring the cognisant experience of a participant and the experiences they have from their own individual perspective (Lester, 1999). This provides the ability to observe and gain insight into the perspectives of others.

3.2.1 Reasons for choosing Qualitative Research

Qualitative research interests include the lives of people, their lived experience, feelings, emotion, behaviours, along with societal movements, cultural phenomena, and international communications (Corbin & Strauss, 1990, p. 11). Qualitative researchers can analyse the subjective meanings that arise, how social incidents are constructed, which highlights the way that people understand, comprehend, and interpret the world (Flick, 2014, p. 542). Qualitative research is an integrative domain that comprises of a diverse range of perspectives that includes the context, culture, and values in which it originated (McNamara, 2001). This approach generates a comprehensive description of experiences, thoughts, beliefs, emotions; and offers interpretations of the meaning of their behaviour (Denzin, 1989). Moreover, the qualitative approach is beneficial for psychologists and has been used extensively in psychology research (Robson, 2011). This is useful for this research as it allows participants' to provide a depiction of what they experience, as well as a deeper, co-constructed understanding of their experiences.

Secondly, an advantage of using a qualitative approach is the pursuit of ascertaining inner experiences to capture how meanings are formed by culture (Corbin & Strauss, 2008). This can be obtained through asking participants' to reflect upon and explore their experience, thoughts, and emotions (Nerlich, 2004) which provides an introspective perspective of an individual's understanding and allows the researcher to encapsulate their experience. Quantitative research would be unable to fulfil this task due to its statistical requirements which would not convey the subtle intricacies that are involved in individual perspectives. As this research is exploring YM individuals MH perspectives, implementing a qualitative approach would encapsulate the way they construct meaning through culture and religion.

Thirdly, qualitative research has room for flexibility, from the chosen method of collecting data (e.g., interview, observation etc.) which can allow room for complex ideas to be explored (Flick, 2011). This is due to the researcher's direct interaction with the participants' during data collection which can aid in inducing perceptions and feelings related to the research question (Buchan & Daly, 2016). Alongside this, qualitative design has a distinctive strength which is the inclusion of the researcher as an essential part of the research process that allows the researcher space to reflect on their own experiences and the influence this has had on the

research developments (Frost, 2011). This is beneficial particularly in this study as the researcher has experiences that are useful in better understanding the participants' perspectives. For this research, implementing interviews and interacting with participants' allowed to build rapport, including a relational space where participants' concerns and experiences are conveyed.

3.3 Grounded Theory

The qualitative research design that will be used in this current project is GT (Charmaz, 2014) which is concerned with building a theory from data analysis and highlights social contexts. GT is appropriate when reasonably little is known about the subject, the perceptions of participants' are being explored and the research purposes the development of new ideas (Lyons & Coyle, 2007). Using GT required a deduction beyond the depiction of what is being said to develop an understanding of why perceptions are the way they are, relating back to existing theories, whilst modifying them in accordance with the data (Charmaz, 2006).

GT methods comprise of structured but adaptable guidelines that help when gathering and analysing qualitative data to construct theories from the data; therefore researchers 'construct a theory 'grounded' in their data' (Charmaz 2014, pg. 1). From early data collection, researchers can start to separate, sort, and synthesize their data by implementing qualitative coding (Charmaz, 2014). Coding is the process of assigning labels to parts of the data that represents what the section is about, allowing comparisons with other areas of the data (Charmaz, 2014).

Alongside the research developments, memo-writing was an important element of the process. Memos are mainly written accounts, but not exclusive to, the analysis which is an essential element of establishing and developing a theory from the data that has been gathered (Charmaz, 2014). Memos are encouraged to be used from the beginning of the study through to data collection and analysis as advancements are made for the research. Memos are developed between data collection and writing the findings draft and are used to capture thoughts, reveal connections, develop questions and direction of the research through interaction with the self about the data, coding, and areas, which further promotes the engagement with reflexivity and preconceiving the data (Snow et al., 2005). This requires the

researcher to pause and observe emerging categories and concepts to encourage reflections that develops theoretical sensitivity (Charmaz, 2006; Chu Tie, Birks & Francis, 2019). Thus, memos can aid in grounding theoretical notions into the actuality and complexity of the data (Holloway & Galvin, 2016).

In GT, 'initial sampling' is used to begin the research, whilst 'theoretical sampling' assists in the direction of where to go (Charmaz, 2014). Initial sampling involves participants' who fit the inclusion criteria (Charmaz, 2014) and the theoretical sampling encourages the ability to review the steps taken or pursue a new direction when new categories are identified in the data (Charmaz, 2014). By gathering more data about the properties of the categories, the properties of the categories are further developed towards saturation (Charmaz, 2014). Saturation refers to no additional data being identified for the researcher to create new coding (Morse, 2015). Concurrently, this method provides more focus than other approaches due to coding and categorising the data as you gather them. When implementing GT, there is the ability to form and reform the data collection, which results in focussing the data and developing knowledge further. This allowed room for discovery when looking at MH perceptions in YM as the interviews were revisited to enhance the data collection process to achieve saturation.

3.3.1 Reasons for grounded theory

Charmaz (1995, 2006) developed the constructivist GT method which has philosophical underpinnings of constructivism. This is where the researcher and the participants' jointly co-construct meaning through data collection and analysis and acknowledges that there is a reciprocity in the research relationship (Charmaz, 2006; Higginbottom & Lauridsen, 2014). A constructivist GT approach supports the aims of this research as it seeks to study and offer insight into an individual and transfer that insight to a shared social process (Charmaz, 2017, p. 299; Bryant & Charmaz, 2007). This is where meaning is generated within social interactions and understanding is conferred and exchanged between people, situating itself within the constructivist research model (Creswell, 2009). This current study seeks to understand the process of religion and culture and the influence they have on the development of MH perceptions in YM.

The current study needed to use a methodology that allowed YM to relay the details of their perspectives. Although the YM were expected to identify as Muslims, the specifics of their background, cultures and experiences can all vary. This suggests that not one reality exists (Charmaz, 2006), and the research methodology is required to accept the intricacies that comes with differences in perceptions. By implementing a constructivist GT approach, the researcher was able to focus on what the participants' were communicating, and the differences in their realities. Constructivist GT holds the central notion that reality is co-constructed and that shared understanding and experiences is what the theory is grounded in (Charmaz, 2006; Mills et al., 2006). Thus, the researcher and participants' construct together as opposed to ascertaining meaning which effects the subsequent theory. From this position, the theory that is grounded in the data that has been collected, is created based on involvement and interchange with participants' as opposed to being determined independent of these interactions (Charmaz, 2006).

The implementation of this methodological approach has allowed the researcher to be aware of their part and impact on the developments of the research theory. One of the main objectors to the constructivist GT view is Glaser (2002) who is rooted in the traditional perspective that the researcher holds a more removed and separate positioning. However, constructivist GT recognises the indeterminate process of research (Charmaz, 2006) and critiques objectivity and researchers who maintain being separate to their data (Charmaz, 2006). Rather, the array of meanings is highly appreciated in constructivist GT where another viewer could derive different understandings (Mills et al., 2006). Therefore, the theory produced is an interpretative explanation of the research area (Charmaz, 2006).

It is important for the researcher to remain aware of the interpretative nature of GT as someone who holds both insider and outsider positions in this research. The researcher and participants' (YM) mutually constructed the data through their interactions. Charmaz (2003) highlights the importance on the researcher adhering to the essential phases that are concerned with GT, such as coding, analysing, memo-writing and reflexivity. These are encouraged to be used in an adaptable way so that the novelty of the researcher can produce a theory as a result of the meanings being constructed, as opposed to be it being made and/or revealed.

3.4 Why Grounded Theory?

The choice of methodology came about when discussing with my supervisor the processes required to undertake a thesis. We explored the suitability of some approaches for this research. GT seemed like the best option as it is beneficial for exploring social processes that do not have enough previous research information, or where there could be new information developed (Salkind, 2010). Whilst Interpretative phenomenological analysis (IPA) has its advantages, including an opportunity to examine the phenomenon in an in-depth way by seeking to understand the experience (Alase, 2017), GT would be suited to constructing a rich description that recognises conflicting and contradictive ideas (Milliken, 2010). Moreover, IPA does not consider the systemic, societal and group influences in conceptualising the development of perceptions which is the focus of this research study. Although some researchers have sought to adapt IPA to address these concerns, others experience philosophical tensions in doing so (Love, Vetere & Davis, 2020).

Additionally, GT generally can adjust to the exploration of diverse cases and is able to establish what is happening within complex processes (Milliken, 2010). This is useful when undertaking research as it can respond to changes that occur and adjusts to different circumstances. This is especially as GT requires an iterative process when relating to the data allowing a theory to be generated from the data (Charmaz, 2014). GT is suited to explaining the process of developing MH perceptions in young people (YP) as opposed to thematic analysis, as thematic analysis allows for concepts and themes to be developed (Clarke & Braun, 2013), but it does not necessarily recognise the factors contributing to processes of development of MH perceptions or allow the creation of a working GT to emerge from the data.

Another benefit to implementing constructivist GT is the inclusion of the researcher, and the understanding that meaning making is co-constructed between the participant and researcher. Thus, researcher bias is noticed and tackled through the inclusion of memo-writing, reflexivity, and the ability to continue revisiting research to ground ideas in the data. Therefore, these inclusions, along with confronting biases that may occur, reminded me of CP ideas around internal supervisor being an observer within (Henderson & Bailey, 2018), attending supervision (Gazzola, DeStegano, Audet & Theriault, 2011), therapy to ensure that transference does not impede much on the client (Parth et al. 2017). This felt parallel to this research and the

implementation of continuous reflexivity to minimise any effect on the following research process.

3.4.1 Participants'

For this research, YM adults between the ages of 18-25 were recruited to take part. There is a small amount of information that offers statistical evidence for the experiences of Muslim YP and their MH. Weatherhead and Daiches (2010) identified that the limited research that exists suggests that Muslims who live in the West do not use the MH services available. They further highlight that British Muslims are unable to access culturally or religiously sensitive health professionals which impacts their decision to get MH help (Walpole et al., 2013). Consequently, the awareness of ways to attain MH help is limited; it is more uncommon for them to be referred to therapy and more likely to be medicated; and are expected to end up in the criminal justice system when difficulties arise (Bignall et al., 2019). This has led to a demand to increase awareness of the MH issues that are experienced by Muslim YP as well as the need to access cultural and faith informed MH services or resources (Bunglawala, Meha & Tunariu, 2021). This is particularly challenging as there remains incredible disparities in YM's attitude towards MH compared to non-Muslims as having a MH challenge is seen as the most upsetting experience, more so than chronic or terminal physical conditions (Musbahi et al., 2022).

The inclusion criteria for this study involved Muslim YP, from any cultural background, between the ages of 18-25. The exclusion criteria included anyone under the age of 18 or above the age of 25, identifies as non-Muslim and people with severe psychological distress that puts them at a higher risk of distress during interviewing or are unable to consent. To ensure the participants' were not at risk, there was an initial screening with potential participants' and one of the questions included was "have you had any experience of mental health difficulties, and psychological support previously?". Participants' were then given an overview of what the interview will involve and made aware that it will be discussing religion and culture in relation to MH and asked whether this would be distressing in any way. The researchers CP training was used to monitor well-being throughout the interviewing process, and I sought support from the Director of Studies (DoS). The researcher also allowed an open-ended time limit after the interview to debrief and allow for participants' to discuss anything that came up for them and were also given signposts to MH resources should they need them.

As some of the interviews were quite long, participants' were made aware of the option to pause or stop the interview at any time prior to the interview. They were also offered the option to pause or stop for a break during the interview process to ensure they were able to continue and to also minimise any harm, tiredness, overwhelm or distress that could have materialised in the interview process. After the interview, participants received time to assess how they were feeling and opportunities to engage in self-care to ground themselves in preparation for exiting the interview process. For the researcher, wellbeing was ensured by conducting one interview in any given day, with some time taken before another interview was conducted. This was also useful for the grounded theory process as transcription, coding and memo-writing needed to take place as part of theoretical sampling, whilst also offering the researcher time between interviews to recuperate. The researcher also turned to peers, supervisor and personal therapist for additional support should anything have arisen, whilst also engaging in other personal self-care activities. Subsequently, the long interviews offered insight into the YM's experience but also required additional provisions to be in place to cater for what they can bring up.

The participants' that were recruited for this study went beyond the '*usual suspects'* – the educated, white, middle-class people who govern a lot of psychological research (Braun & Clarke, 2013, p. 58). Potential participants' were informed about the research through word of mouth, Instagram (researchers story, which was reposted by followers on their profiles), WhatsApp groups (Islamic societies, mosque groups from London and Bristol, social groups). This involved putting advertisements on populated Muslim groups and pages, as part of universities (located in Cardiff, Bristol, Bath, and London), social groups (who then advertised on their social groups etc) and religious groups that had a wide reach from Bristol, Wales, and London (Braun, 2008). Meanwhile, social media platforms were used to post ads for the project which allowed for a wider reach. When posting online, there was careful consideration to disabling tags and comments under posts to protect confidentiality or any disclosure of identifiable information and posts were primarily on 'stories' on Instagram that provided an email address and number to contact via WhatsApp.

A sample size of 10 individual interviews, recommended by Charmaz (2014), was collected from this research. There were 15 potential participants' who made initial contact to participate in the study, but due to a lack of response, did not take part. There was a total of 7 females and 3 males who took part in this study aged between 18-25. All the participants' identified as heterosexual and had a religious identity of being Muslim. The ethnic backgrounds of the participants' included Pakistani, Bangladeshi, Indian, British, Arab, Algerian, Maldivian, Somali, and Kashmiri. Overall, 6 participants' had accessed MH services prior to the research taking place, and 4 participants' had not. An overview of the demographics is provided below in *Table 1.*

Participant	Age	Gender	Ethnicity	Sexuality	Religious Identity	Previous use of MH Services
Layla	25	Female	Pakistani	Heterosexual	Muslim	Yes
Nasir	23	Male	Bangladeshi	Heterosexual	Muslim	Yes
Rabia	22	Female	Somali/ Black/ African British	Heterosexual	Muslim	No
Aafiyyah	18	Female	Pakistani	Heterosexual	Muslim	Yes
Zahra	21	Female	British Pakistani	Heterosexual	Muslim	No
Hawa	25	Female	British Indian	Heterosexual	Muslim	Yes
Fatiha	22	Female	Maldivian	Heterosexual	Muslim	No
Najia	23	Female	Asian/Arab	Heterosexual	Muslim	Yes
Yahya	21	Male	Algerian	Heterosexual	Muslim	No
Ahmed	22	Male	Pakistani/ Kashmiri	Heterosexual	Muslim	Yes

Table 1: Demographics table for participants' in this research. All names that are included are pseudonyms from the YM who took part in this research.

3.4.2 Data Collection

The data was gathered using semi-structured interviews to investigate the process of development of MH perceptions as affected by culture and religion. Interviews are suited to

this study as they focus on the impact of culture and the process of development of MH perceptions for YP to observe (Braun & Clarke, 2013). Interviews produce open and interactional spaces for the participants' to be able to narrate their experiences (Charmaz, 2014). The interviews were valuable for this research as they allowed the researcher to maximise on the direct interactions with the participants' to implement the social constructionist epistemology and the researchers own participation in the data collection and construction of reality.

The interviews were conducted with participants' who fit the inclusion criteria to collate an exploration of first-hand experiences using open-ended questions that led to obtaining detailed responses, meanings and experiences related to the development of MH perceptions of Muslim YP. The interview questions were formulated to encourage the participants' to tell their story in the way that suited them. The interviews focus was to allow for exploration as opposed to interrogation (Charmaz, 2014) and were split into open-ended questions and additional intermediate questions to provide prompts for the more difficult areas of conversation to draw on the views and experiences of the participants' (Charmaz, 2014).

Developing the questions took some time to frame in the context of the research, especially in terms of ensuring the breadth and depth of the topic area could be captured. Charmaz's (2014) guidance on constructing interview questions was used as they allowed the interviewer to structure the questions in a way that allowed them to revisit threads of questioning that occurred before, and/or continue with the line of questioning. This was especially as the interview schedule had sections that focussed on MH, then religion, and culture in relation to MH perceptions which often overlapped or related in some way (*see Appendix G)*. There were times where the participants' were asked one question which led them to discussing areas of their life that covered a few of the questions on the interview schedule. In those circumstances, the researcher would leave space for that to occur, with some clarifying questions or reflections to encourage the participants' to continue their stories, as encouraged by Charmaz (2014). The researcher would still ask some of the questions if it was relevant to see if participants' would like to add more information in answer to the question. Ending questions were also added to regulate and bring the participant back to a 'normal conversational level before ending' (Charmaz, 2014).

Due to the nature of interviews, there were a multitude of factors to consider, such as interviewing strangers, power in the interview, gender, societal positions, and distress (Braun & Clarke, 2013). Therefore, a level of researcher and participant alliance was developed to produce rich data whilst developing and upholding respect between the two parts (Guillemin & Heggen, 2009). Rapport is the foundation for effective communication, leading to gathering meaningful data (Youell & Youell, 2011). This was implemented in this study by offering time prior to the interview process for any questions or queries about the research and/or allowing space for nerves and worries to be expressed. Once this had taken place, then the interview began. After the interview process, the participants' were then given some time to express their thoughts and feelings, along with a check-in to see how the research has left them, along with time to bring them back to a similar place to how they began. Each interview process lasted between 1.45 hours to 4 hours from start to finish.

The interviews were facilitated through active listening by providing verbal cues, non-verbal reassurances like body posture, eye contact, which can improve rapport (Hull, 2007). Leach (2005) noted that avoiding passing judgement, jargon, technical language, and authoritative demeanour and limited researcher disclosures help maintain boundaries whilst building connection. This is particularly where there is risk of informal interaction due to belonging to a similar religious group. One of the ways this came up in this research was with inside jokes that relate on a broad level to Muslims as a way of relating or understanding what comes up. The use of the CP training was helpful in implementing active listening, empathy, and unconditional positive regard (UPR) and helped in establishing trust and rapport in building a relationship with the participants' (Bozarth, 2007; Frankel et al., 2012).

After gaining the participants' consent, demographic forms being filled, and the participants' having gone through the privacy notice, the interviews were conducted. The interviews were audio recorded and transcribed verbatim following the interviews and placed in a restricted folder on UWE OneDrive. Alongside this, a word document was created to record information on the date that the interview was conducted, purpose of the data, the ways that the data was created and analysed as well as an explanation of how codes and abbreviations were used. This was kept with the data files to aid the interpretation of findings. The password for the audio

folder was kept separately to ensure participant confidentiality and stored with encryption on UWE OneDrive. Only the researcher had access to the audio recording and the supervisors had access to some of the transcripts that were stored on another folder on UWE OneDrive with a password.

The participants' information was always anonymised to ensure that they were not identifiable. The participants' data was protected by implementing a pseudonym in place of their name. Any identifiable information such as place of worship, work or home address was not included. Instead, there was an indication in the transcription that identifiable information has been removed. This was ensured by forking through and consulting with supervisors in the process to ensure that the anonymity is maintained. The hard copies were disposed safely using UWE's confidential paper disposal.

3.4.3 Data Analysis Process

Charmaz (2014) proposes an initial analytic process that begins with coding. GT coding entails the researcher to pause and analytically enquire about the data collected at regular intervals. GT involves no less than two main stages, the 'initial' and 'focussed' coding.

'Initial coding' is the first part of the data analysis where the researcher went through the transcription line by line in attempts to pinpoint codes to classify, name or categorise words and phrases that highlight what is occurring or inferred in the data. This was achieved by going through the raw data from the interaction that the researcher had with the participant but pulls the researcher into an 'interactive analytic space' (Charmaz, 2014, p. 109). By remaining open to this process, the researcher was able to draw observations, and subtle meanings that surfaced from the data. This was to offer insights that can direct the researcher to new ideas that can be investigated analytically through writing memos. This was then used to update the interview schedule and collect more data as ideas emerged.

Transcript:
Participant 4: There is also the obsession with skin colour the fair skin colour, the fair skin gets more value as you grow up even within friend's fair skin girl gets more value.
Initial Coding:
Value based in skin colour, judgement, self-worth, criticism, comparison, preference

Table 2: Illustration of initial coding process extracted from data.

Following this, 'focussed coding' can influence the analysis by the researcher observing the most valuable initial codes to synthesize and conceptualise the broader data. This is the process of determining the relationship between ideas and where new thoughts or categories arose. These concepts are abstract and 'higher in level' than what they signify (Corbin & Strauss, 1990, p. 7). This process is important, as the initial codes can influence how meanings are then defined. By knowing that the meaning making is co-constructed, the researcher can maintain a critical eye throughout the research by repeatedly revising the codes and checking it against the main bodies of data. Consequently, subcategories can emerge, as shown below.

Initial Coding: *Value based in skin colour, judgement, self-worth, criticism, comparison, preference*
Sub-Categories: *Unhelpful Evaluations / Discrimination/ Personal Impact*

Table 3: Illustration of observing the link between initial coding and focussed coding.

Memo-writing here allowed for a break in the analytic process to recognise the connections that are forming in the data. This comprises of the researcher writing about the codes and data, which helped in establishing theoretical categories and was maintained throughout the research process. Memo-writing encourages 'theoretical sampling' which begins with the data, leading to the formation of provisional ideas about the data, and exploring these notions through a more empirical investigation (Charmaz, 2014). Theoretical sampling review what has been conducted so far or leading the research in another direction. Memo-writing allowed the researcher to identify emerging ideas, which highlighted commonalities or contrasts which encouraged more specific questions in the interview schedule. For this study, the researcher utilised theoretical sampling by continually reviewing the category and the data to enhance the conceptual level of the categories found. Through this, the concepts for the theory became clearer as the processes developed.

Categories found in initial and focussed coding were assimilated, proposing an initial theory. The core categories are chosen to formulate a 'conceptual label' that represents the narratives and data of the participants' (Strauss & Corbin, 1990, p. 121). This stage recognises the reconstruction of the participants' stories by the researcher with the aim of encouraging the voices of the participants', despite the researchers own inescapable interpretations (Strauss & Corbin, 1994, p. 128). Throughout this process, GT encourages continuous comparison between the categories and the data as an essential element of the model, with the presumption that a theory will surface (Corbin & Strauss, 2008).

The researcher generated data through interviews, coded the data using initial coding, synthesised the data through focussed coding and memo-writing, and analysed the data intermittently for this research. The initial coding for each transcript contained around 200 initial codes from the raw data (approx. 2000 altogether). The codes that had similarities were revisited and merged to contain wider, more abstract notions that continued to allow the codes to progressively become more focussed until there were around 76 more focussed codes. The themes were then organised (see Appendix I) until there was an initial emergence of the theory that contained about 22 codes. The initial description of the categories followed an exploration of the connection between the themes.

Throughout the stages of analysis, the researcher noticed recurring perceptions and themes in the data that was obtained by continuously comparing the data until the categories were saturated. When similar themes are produced consistently, the researcher is ensured that the data is as saturated as possible (Glaser & Strauss, 2017). By achieving this, the reliability of the study is increased (Breckenridge & Jones, 2009). Nevertheless, declaring complete saturation would not be accurate as there are restrictions and limitations of data saturation following time and data exhaustion constraints in the data collection and analysis process (O'Reilly & Parker, 2012). Moreover, there is hesitation in asserting that complete data saturation has been accomplished as Glaser and Strauss (1967) put forward that attaining complete saturation is not possible as there will always be new developments in data. This was overcome by regular communication and guidance from the researchers' supervisor and peer support in validating the results. This meant that when the later interviews in this study were analysed and no new codes and categories emerged, the end of the data collection was signified.

3.5 Risk & Ethical Issues

This project had been approved by FREC (Ref: R4546) on the 13th of October 2021.

Informed consent indicates gaining the permission of an individual before continuing with the research. It requires informing the participant of what is expected, risks and the nature of the research which allows the participant autonomy to agree or disagree in taking part (Lo, 2009). Consent was obtained by participants' signing the consent form that was provided alongside the participant information form and all the ethics forms (*see Appendix C, D, E*). There are many ethical practices that have been developed with the intention to not repeat mistakes, and safeguard individuals and promote selfhood (Lo, 2009). However, when applied to non-Western communities, there are a multitude of factors to consider such as labelling of what constitutes 'well-being' (Al-Saadoon & Al-Adawi, 2019). This required being aware of different cultural meaning that arose and to include and work with the diversity that was present for this research.

Due to cultural sensitivities and individual differences, the nature of the topic may have been difficult for participants', exposing them to potential distress when discussing experiences from the past and present. Before the interview process, potential participants' underwent a screening to identify any vulnerable participants' who may have decisional or communication issues or were unable to comprehend the details of the research and their rights which would have affected their ability to provide satisfactory consent; they would not have been able to participate in the study. The researcher used skills that was acquired from CP training, like safeguarding, signs of discomfort and MH awareness to manage any risks that arose. These issues are also addressed in the submitted Risk Assessment Form (*see Appendix B*).

The participants' were provided with a follow-up check-in and resources that they could contact after the interviews for additional support. The participants' were also fully debriefed before, during and after the interview process to give them as much support as possible. Often, there was about 30 minutes to an hour after the session where the participant and the researcher had a conversation. To ensure their psychological, emotional, and physical safety, participants' were provided with resources such as counselling or helplines and would have

been withdrawn from the study. If the participants' withdrew under any condition that did not allow for the completion of the interview process, e.g., voluntary withdrawal. It was important to consider how the recent global pandemic (Covid-19) may have influenced the lives of the individuals, emotionally and physically, thus taking into consideration the way in which support can be provided on an individual basis. Participants' were reminded that they can withdraw at any time during the interview and up to 15 days post-interview whilst transcriptions were being produced.

Due to the current global conditions of Covid-19, it was important to consider how the interview process might be impacted, thus, modifying the methods of interviewing. The use of Microsoft Teams was used to conduct interviews. This required careful consideration of the impact of doing interviews virtually. Some participants' may have found accessing their private space difficult with some disruptions, and internet connection (Shaw, 2010), artificial environmental distractions; all of which may have impacted the depth and quality of information received (Jowett, Peel & Shaw, 2011). Therefore, there were attempts to ensure more time was available for each participant to allow room for any unplanned challenges, back up phone options and the option to reschedule. When there were disruptions, participants' were given space to ensure their privacy was obtained again before continuing with the interview. The research utilised UWE Ethics and BPS Code of Ethics and Conduct (2018), ensuring privacy, autonomy, consent, and debriefing. In the case of distress, withdrawal was ensured/ prepared during the interviews and up to 15 days post-interviews, along with support resources for the participant to ensure their safety.

3.6 Reflexivity

Researchers are not considered to be passive vessels whereby data is dispensed, dismissing the examination of personal values whilst asserting neutrality in GT (Charmaz, 1990). Charmaz (2014) argued that it was impossible for the researcher or participant to enter the situation uninfluenced by this world through expectations, knowledge, experience, judgement, and other personal assumptions. Nonetheless, researchers are required to reflect what they bring, what is seen and how it is seen. This can include observing one's own 'insider' and 'outsider' status (Braun & Clarke, 2013; Gallais, 2008).

Reflexivity is an important part of GT as the researcher is encouraged to reflect and maintain notes on their development throughout the research to be able to recognise where personal bias may come into play (Charmaz, 2014). By keeping engaged in reflexivity, it seeks to monitor the appearance of the researcher's implicit assumptions (Charmaz, 2014). One of the ways that is intended to maintain a reflexive approach through the research, is to implement a research journal (Morrow, 2009) that would help in identifying and reflecting on the researchers assumptions, both personally and theoretical, that may contribute to the direction and lens of the research.

3.6.1 Insider Status & Outsider Status

An important aspect of the research process is the positionality of the researcher as an insider or outsider relative to the participants' which impacts the entire research process, data, design, and interpretation (Zempi 2016). An 'insider status' is understood as a researcher who considers themselves inside the population of the study, in which case they need to acquire data whilst maintaining an 'eyes open' approach, whereby they assume that they know nothing about what is being investigated (Asselin, 2003). Asselin (2003) acknowledged that whilst the researcher is a part of the culture of the research, there are still 'subcultures' that might not be understood; thus, the concept of *bracketing* comes into place. *Bracketing* is the process of putting aside ones' assumptions about what they think they know, to not limit any influence on the research (Williams & Morrow, 2009). Alternatively, having 'insider status' can help to elevate the quality and richness of the research due to having a level of understanding of what is being observed (Gallais, 2008).

There are some benefits to having some insider perspective as it may mean that the participants' may share aspects of themselves that would be harder to express if they were speaking to an outsider (Kanuha, 2000). For example, Talbot (1999) found that her participants' had expressed that had she not been a bereaved mother, they would not have shared certain elements of their story with her. However, it could also be argued that having insider status would also prevent certain things to be shared due to fearing judgement or sharing insight participants' may deem controversial (Bartunek, 2008). By locating the positionality of the research, it allows room for 'fixed' aspects such as sex, race, skin colour, nationality, and more 'fluid' ideas such as political stance, life experiences that are more subjective in nature (Grix,

2019). Throughout the research process there was a critical review of detecting, forming, and conveying positionality (Cohen et al., 2017). By engaging in reflexivity, the researcher was required to be aware of positionality and how this may or may not impact the design, implementation, and interpretation of the findings (May & Perry, 2017).

The 'outsider status' is an important concept that has been explored by social scientists particularly due to their experience of observing groups that they are not members of (Asselin, 2003). Although maintaining an outsider perspective does not have a negative effect on the research, it challenges the reflection on what it may mean for participants' who identify with a group as a result of shared experiences such as ethnicity, race, gender, sexuality, religion etc. (Angrosina, 2005). However, it is suggested that having an insider or outsider perspective is not the only component to good research, rather allowing space to be honest, open, and deeply curious in the experience of another and attempting to sufficiently represent their experience (Angrosina, 2005).

3.6.2 Researcher Reflexivity

As the researcher, I have had an interest in MH, particularly through the lens of religion and culture. This is because I am a Muslim who follows the religion of Islam and have had experience of MH difficulties, in a culture that did not acknowledge the existence of MH struggles. I found this concept difficult especially as from what I knew about religion, it acknowledged MH struggles, however, that was not something I heard or was acknowledged from the society around me. I became aware of the nuances, complexities, differences, similarities between culture and religion and the contribution that they had on individual lives, especially as there were discrepancies between what was culturally expected versus religious expectations. I became curious to know and understand the experience of others who follow Islam and the role that religion and their cultures play in their perspective of MH.

I maintained a reflective journal throughout the doctoral process to understand the process of MH perception development along with ascertaining my thoughts, feelings, and perspectives throughout conducting my thesis. Using the reflective journal was useful for becoming aware of, and uncovering my own perspectives, experiences, and beliefs (Dodgson, 2019). By using the journal, I could be transparent throughout my research, during moments of uncertainty,

which was helpful in revealing my assumptions and subjectivities. Writing in my personal journal, I was able to express ideas and connections, and initial thoughts which helped separate and reflect on what my experience was and that of my participants'. This was important for me to ensure that I reflected on all aspects of the research, the changes that occurred, the difference in my felt experience to ensure that the outcome of the thesis is as transparent as possible.

Here are two extracts from my reflective journal:

4th April, 2022: *Sometimes I feel like I've lost my creative juices, I have reached somewhat of a writer's block and feel as though I don't have very much that is interesting to say – which is odd as I know to some extent there is importance in what I'm doing but I feel I can't access those parts of me at the moment. I can't quite touch the parts that feel really important to grasp what it is I am trying to say. I don't know if that's because i had checked out and now in the process of trying to check back in or if it's because more widely I'm finding it hard to know the direction or what is happening.*

(Here is where I started to feel differently about this research).
2nd June, 2022: *Personally, I feel in a place where I am less controlling of the narrative and willing to see where it takes me. I used to have the worry that my research would somehow impact or influence my belief system – but I am in a place where I don't feel that – I feel that people all have their different perspectives and its okay to be individual but also that I am ready to let the data guide the research.*

The 'insider status' that is present in this research includes belonging to the same faith as the participants', being of a similar age and potentially interviewing participants' of the same ethnic background, which is Algerian, as well as identifying with the gender of some of the participants'. The 'outsider status' held for this research could be growing up in a mixed household, comprised of more than one ethnic background (British Algerian and Kashmiri), majority white and non-Muslim area, different experience in life and being a separate individual.

The position that I held in this research was on a continuum and I moved along the continuum depending on the participant that was being interviewed. This presented itself in this research as there were some participants' that I shared some insider status's with, whilst others I

experienced more of an outsider position. I shared the same faith as all the participants' in this research, however, would interchange between sharing the same gender, ethnic background, and some themes of religious or cultural understanding. I experienced more of an outsider status due to my upbringing, such as not being raised amongst Muslims, different life experience, and my relationship with religion and culture.

To begin with, I was hesitant but curious about what the interview process would entail particularly around its differentiation from the therapeutic approach with clients. As I progressed with the interviews, I noticed that the therapeutic skills were beneficial when exploring the participants' perceptions, especially when being able to offer reflections to provide a deeper insight into their meaning making. My first two interviews set the tone for what was to follow, particularly when it came to revisiting the interview schedule and adjusting how the interview took place for later participants'. For example, I found that going straight into the interview after briefing participants' on the research felt overly formal, and perhaps did not 'warm up' the interaction to ease the flow of the conversation. Due to this, by the end of the interview process, participants' began to engage in the momentum resulting in further discussion after recording had ended.

Following this discovery, I transcribed the initial participants' interviews, completed the initial coding, sentence by sentence, describing and acknowledging meaningful aspects to the data. I did memo-writing alongside this which helped document and discover some ideas around the codes whilst also noticing themes that were useful to add to the interview schedule (Lempert, 2007). For example, questions around gender differences through the lens of religion and culture that were evidenced in the first sets of data. Once I had revisited and made changes to the interview schedule, I adapted the way the interview took place. I provided the option and space, prior to the interview for initially getting to know one another, along with space for any informal discussion about concerns regarding the interview, questions around the research and/or discussing elements of what brought them to participate in the research. I would then check their readiness to start the interview, remind them how the recording will work and proceed with the interview. Once the interview was complete, there would also be space provided for participants' to reflect on the experience or information that they disclosed, ask questions, and for me to remind them of their right to withdraw.

By changing and engaging with the interview this way, a rapport could be built, providing the participants' the opportunity to feel connected to their experience along with having agency and assurance over what they disclose and the level in which they would like to. Some participants' expressed feelings and concerns that they will think of something to add later, or their hopes to add value to the research as they have felt alone in their experiences and would like their voices to be heard. I felt a level of satisfaction in the discussions that were had, they felt full and thorough, especially as there was no expectation for the participants' to use the space and time, as it naturally differed between each participant. My longest interview process lasted for 4 hours. I found it necessary to ensure that the participant felt grounded and contained, especially as she expressed having 'emptied' herself and found that she had explored a lot of her experiences. I found this experience to have added incredible value to my research in that it validated the need for the research and provisions to be given in. Whilst this was the case, the long interviews also required me to take time away from the research to gain support for myself and manage any transferences and managing any overlaps and similarities – but also the differences to allow myself to come back to the research with a clearer understanding of what is being communicated. From this interview, I had to take time away from the research before engaging in her open coding, take some reflexive time as it felt important to create space before revisiting the interview as it felt full, intense, and rich.

As I transcribed and proceeded with initial coding, I would take time out to do memo-writing and write in my reflective journal about the interview process, what was discussed in the interviews, what felt close and relatable, what didn't to ensure my awareness and influence on the research. This helped create space and understanding, reminding me of the supervision that's received when seeing clients, to distinguish and make sense of what's happening during the co-construction of ideas. In the focussed coding stage of my research, my attempts to shorten the codes and assess recurring themes, as well observe new ones, was an experience of doubt about whether I was developing ideas and categories in line with the data. This resulted in continuously revisiting and comparing codes and checking if they align with the data. I did this by implementing a more creative approach, surrounding myself with colour and A3 paper, cut-up codes, organising and changing them which helped in developing categories.

I experienced a period of creative block where I was unable to formulate ideas, felt disconnected and confused by my codes which I reflected on in my journal. I spent some time freewriting and reconnecting to my research and found that there were groups of codes and categories that began to emerge. At first, I felt compelled to draw up a list of categories and sub-categories. However, as I was explaining it to my supervisor, it was clear that there were nuances that needed to be explained and so a list didn't seem appropriate. So, during focussed coding, I began developing connections and ideas about how the categories interlinked, the narrative that it demonstrates which is what ended up emerging from the work and data.

There were many moments of doubt, wondering if I was doing it 'right' and doing the research justice. This happened regularly and throughout the research, however, decreasing in intensity as time went on due to external events that occurred alongside conducting the research. At university, the topic of religion arose, bringing forth the complexities of how religion is perceived and understood. The discussions that were had instilled a new sense of motivation for me, hearing the opinions that were held, along with hearing the voices of my participants' and wanting to do justice to the research as their concerns felt parallel to what was happening in the professional world. For instance, some of my participants' spoke about their worries about talking to a therapist who may not understand religion and the world in which they come from, concerns around the lack of Muslim therapists, whilst wanting a Muslim therapist to have a baseline understanding, particularly around the nuances of being a Muslim that is often a shared language that might feel too difficult to explain. These events fuelled my confidence towards the importance of this research along with my eagerness to justice to the voices and experiences of YM.

3.7 Chapter Summary

In this chapter, I have highlighted my epistemological position, implementing the constructivist position for this research. This is contingent on the way the participants' perceive the topic that is being researched (Creswell, 2003, p.8) and acknowledges the influence of the researchers' circumstances and experiences. This chapter highlights the use of GT for this research, exploring the design, recruitment, data collection, data analysis, reflexivity and ethical issues that have happened in this research to safeguard the research quality.

CHAPTER 4: RESULTS

This chapter explains the findings of the cultural and religious influences that impacts MH perceptions in Muslim YP. During this stage, the data that was produced from semi-structured interviews were analysed, implementing methods from Charmaz's (2014) GT.

4.1 Grounded Theory Analysis

There were three main steps in the GT analysis. Firstly, codes were identified which emerged from the raw data that created the concepts for the results. Secondly, the concepts were compared to one another, which proceeded to develop into new ideas and categories. From this, the relationship between the categories began to materialise throughout the conceptual comparison process. Lastly, this led to classifying one main category that characterises the experiences of YM developing their MH perceptions. The main category is ***Navigating Complex Multiplicities,*** which emerged as the overarching theme, that addresses the challenges that YM have in the way culture and religion influence their development of MH perceptions.

The emergent theory from this research demonstrates the impact of religion and culture on the processing that YM go through, the way that they navigate multiple dualities that are present in their lives, its affect, the individual discovery that they embark on, the resources that they encounter and the way they integrate these elements into their perceptions. The process that characterises the development of MH perceptions for YM based on the participants' narratives will be explained then the subcategories that emerged during the analysis process will be discussed providing examples from the data before concluding the analysis section.

4.2 Diagram of Findings

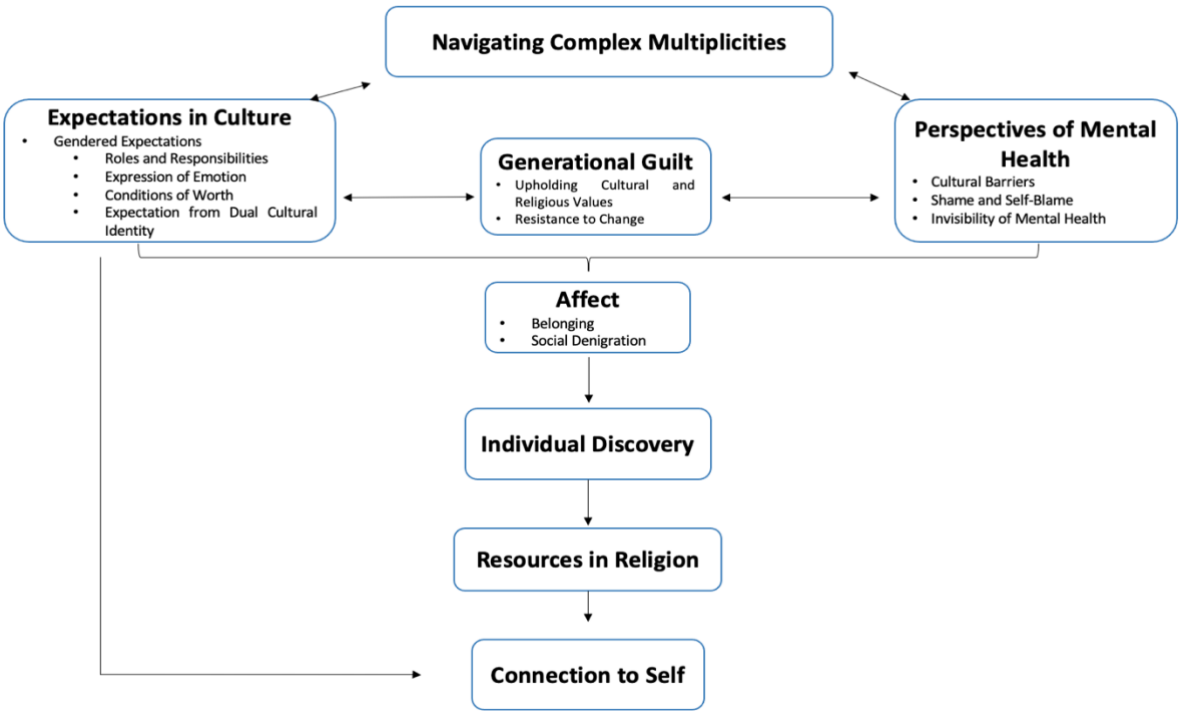

Figure 1: Concepts that emerged through Focussed Coding.

It is important to define what 'multiplicity' means for the purpose of this theory. 'Multiplicity' is explained in Merriam Webster Dictionary (2022) as a 'large number or variety of factors in a system'. Navigating Complex Multiplicities informs the process that YM undergo to balance and do justice to all these different aspects of their lives. Throughout their life, young Muslim people encounter many dualities within their multiplicities such as their cultural and religious identity and perspectives within those paradigms, intergenerational expectations, whilst living in a Western world. 'Duality' here is described as 'an instance of opposition or contrast between two concepts or two aspects of something: a dualism' (Merriam Webster, 2022). The complexity of these multiplicities stems from their often-dichotomous standpoints (i.e., dualities), resulting in a split in various aspects of their experiences which can influence the way they perceive MH. The split leads to varying Perspectives of Mental Health, Generational Guilt, and Expectations in Culture. A split occurs when a person is left holding multiple dual perspectives that conflict with one another. For example, the participants' in this research experienced duality in a sense of self, including their religious, cultural, and British identities and the expectations that was required for each, whilst trying to maintain an alignment with

their sense of self. Consequently, their sense of belonging to certain communities is impacted. This contributes to their experience of MH challenges, and the way they understand and approach support for their mental well-being.

These three separate categories can be cyclical in nature as they are interlinked. Expectations in Culture can often be a cause of Generational Guilt and therefore influences Perspectives of Mental Health. Equally, Perspectives of Mental Health can alter Expectations in Culture which can also induce Generational Guilt. understanding of MH can be influenced by cultural expectations as they shape the way individuals observe their roles, emotions, values, and management of dual identities. This can be further impacted by the pressures of managing the hopes and outlooks of previous generations, their belief in MH and its influence on YM.

This process of Navigating Complex Multiplicities produces an emotional response, referred to as Affect, that begins to develop over time, influencing behaviour. The emotional consequences can lead YM to become aware of the MH struggles they are experiencing and shed light on the ways that they understand, approach, and manage their MH. Consequently, and perhaps simultaneously, individuals initiate an Individual Discovery process which is a personal journey that questions the legitimacy of religion and culture and start to understand how to distinguish between the two. This occurs through seeking knowledge about their religion, questioning religious perspectives of MH, and discovering that there can be discrepancies in interpretation and implementation of religious concepts within cultural contexts. Through this understanding, YM explore what is important to them, increasing their knowledge of religion to seek answers for the challenges they are facing.

Through Individual Discovery, they identify Resources in Religion that provide support, understanding, and methods that can be included as part of their recovery, healing, and maintenance of their MH. As part of their Individual Discovery, YM may struggle with balancing potential incompatibilities between culture and religion. YP may want to continue embracing elements of their culture and go through a negotiation process of prioritising parts of culture that align with their religious beliefs and sense of identity. This negotiation is made in accordance with their experience, where a young person identifies parts of culture that they value and work to incorporate them into their life within the boundaries of religion. This is

dependent on the context, level of religiosity and importance of culture and the way these multiplicities were navigated. This is where YP discovers their sense of self, perspectives, beliefs, and identity in Connection to Self which allows them to apply this to the way that they perceive MH depending on the context that they are in.

Above highlights an overview of the process that YM go through in conceptualising their perceptions of MH. This will be explored in detail below through the explanations of each category.

4.3 Core Categories

The findings of this research indicate one main category and seven subcategories that reflect the participants' experience of the impact of culture and religion on the development of their MH perceptions. The categories represent the process participants' went through as they developed their MH perceptions through cultural and religious influences. This includes their initial experiences and the processes they encountered that represents their trajectories over time. Below, each category will be explored in further detail, providing quotes obtained from the interviews which will be used to ground the findings in the data.

4.3.1. Core Category: Navigating Complex Multiplicities

The main core category that emerged from the data analysis was Navigating Complex Multiplicities. From this, seven subcategories were recognised from the data: Perspectives of Mental Health, Generational Guilt, Expectations in Culture, Affect, Individual Discovery, Resources in Religion and Connection to Self all of which contribute to Navigating Complex Multiplicities which will be explained in the following sections.

The main category became noticeable as participants' explained different barriers and challenges that they encountered throughout their experiences. Navigating Complex Multiplicities informs the way YM people make sense of their perspectives within multiple paradigms that they belong to, which have their own sets of rules, regulations and expectations that can be conflicting in nature. This can impact the way that they present themselves, the perceptions that they formulate and where certain messages they receive are attributed to.

> *It's like imagine you're a rubix cube and each side of you is a different colour, like the different parts of you. You can only be one side with one group of people and then another side with another group of people but all you want is to mix it all up and be your full true self all the time everywhere without having to change what side you're presenting to others depending on who they are.* (Najia)

> *Quite challenging in a sense, you feel like you can't really be an individual or you feel like it's difficult because you feel like anything you do reflects on your family kind of thing, like oh from a culture point, it will always be, oh so and so's, what was it, so and so's dad did this, or you'd be known as like uh so and so's son rather than, it wouldn't be by name it would be by association.* (Nasir)

Najia illustrates the control that is required when navigating communication with others, demonstrating that she only reveals parts of herself to different groups. She uses the rubix cube as a model to explain how only one side can be presented to one group of people at a time. She comments on how she wants to be authentically herself, without trying to manage what parts of herself are seen depending on social context. This highlights the difficulty of incorporating her full self in all types of social interactions.

Additionally, Nasir emphasises the difficulty in being an individual in his community due to the way that he is received by others, whereby his actions have consequences that impact his family. This indicates the lack of freedom or room to make individual mistakes without it having a collective impact. This, in conjunction with being known as the child of someone else as opposed to the use of his allocated name, further highlights the blurring boundaries between the self and others, and the way one influences the other.

> *I think there is a little bit of a stigma but I don't know what it is but it can be sometimes like its cultural I think that I just I'm not sure because like I've experienced it from Arabs and Asians so far that I just don't know what it's if it's kind of if it is that or if it stems from that their religious or if it's their tradition or their cultures and then they're putting that onto religion because that's their way of put implementing it and I've thought about it a lot but I can't figure it out.* (Hawa)

> *I think, for example the competitive thing, like the qualifications and stuff, I don't think it's something that would be like in our religion I don't think it would be something that would be approved of I think in our religion it's about accepting people for who they are and not about how high that person is doing due to their qualifications.* (Fatiha)

Hawa explains the process of navigating where information regarding stigma derives from. She demonstrates the negotiation process that she must undertake to process and understand where the messages originate as she receives similar messaging from her Arab and Asian cultures. Therefore, it is more challenging for her to decide how to implement these perceptions into her life. She explains the confusion that can arise as there are cultural expectations that are put onto religious acts, or the importance of religion being placed on cultural practices. In Fatiha's excerpt, she provides an example of how religion and culture address a person's value. In culture, a person's qualifications are an important factor to how they are perceived, and measured, and therefore valued. However, she comments that religion is accepted of all people based on who they are not what they attain. This highlights the development of YM MH perceptions as they attempt to distinguish between existing dualities to then adopt and/or develop their own personal observations.

4.3.1.1 Subcategory 1: Expectations in Culture

The first subcategory developed from the data is **Expectations in Culture.** There were many participants' who conveyed cultural expectations that were prevalent in their lives. Cultural expectations involve the script that exists in line with cultural norms, such as gender differences and the corresponding behaviours that are advocated by the social groups that they belong to (e.g., family and community), what is allowed and what is not. The YM had varying degrees and/ or different aspects of these pressures that altered according to their situation. Some of the cultural expectations included *Gendered Expectations* and *Expectations from Dual Cultural Identities.* These will be explained further below.

4.3.1.1.1 Gendered Expectations

Many of the young Muslim participants' described lived or observed experiences of *Gender Expectations.* The expectations that became apparent are three-fold. The first is *Gender Roles and Responsibilities,* the second is *Expression of Emotion* and third is the *Condition of Worth* in Muslim YP. A few of the experiences are demonstrated below.

i) *Roles and Responsibilities:*

In these accounts, there is a strong reference to women 'doing' many caregiver activities to ensure that the home, and family are taken care of. There is an emphasis on women managing many aspects of home life, and sometimes work life, and being the ones who 'look after'

everyone, men are perceived to be the ones who are 'looked after' and perceived as more important. These differ slightly between the descriptions.

> *There's always a lot of pressure on women to be the housewives and homemakers and the childrearers and the ones who take care of extended family … but no one really takes care of the wife.* (Layla)

In Layla's experience, there seems to be a gendered script that women are expected to follow, that is tied to the home and family, where they are expected to bear the responsibility for all domestic duties. There is a sense of feeling unseen in her account regarding doing the caregiving but without receiving care in a similar fashion.

> *I still feel like female Muslim, or female Bengali Muslims are still fitting into that stereotype of being a housewife, not going to university or not working*. (Nasir)

> *So my heritage I would describe it is patriarchal but with a very strong female influence behind it for example If I talk about my aunt… she would get up even he would send money back home, but she would get up around five o'clock in the morning and go into town and come back and from seven to make kids food then goes back into town then come back the whole time was going back and forth and whenever I went into town it was sort of like there was so much men just sitting around just eating whilst the women were selling stuff in the stores and stuff like that.* (Rabia)

Nasir also indicated the expectation for women to take on household responsibilities, over pursuing education, or a career. For Rabia, it seemed as though society was viewed as patriarchal however as women were involved in the work, it meant that women were involved in most areas of work. Women are expected to take care of the family in addition to working, indicating more responsibilities that are not as shared, in comparison to Layla's account where the men were breadwinners.

> *In our culture like everyone loves boys and they essentially sit around, and you just feed them and stuff… My culture has told men to be as powerful but, in our religion, even if men are in those high levels … helping people is approved of in our religion, but I think culture has caused these kinds of things to go.* (Fatiha)

> *Within our culture, men and the boys are more important than the girls and we should be promoting and establishing good relationships with our children especially the boys within our families and the girls should sort of that stereotypical*

work from home and think about the family and think about other aspects of life. (Ahmed)

In Fatiha's and Ahmed's examples, they explain boys being regarded as more important than girls. In Fatiha's example, she explained that it was expected for women to serve the men. Fatiha commented on the difference between religion and culture, in that religion advocates for men to be in positions of power and success whilst remaining active within the home, but she suggests that culture has removed that aspect, creating a binary within roles and responsibilities. Ahmed highlighted that there is also a preference towards boys being considered as more important. He further highlights the expectation for women to be thinking about the home and family. For these participants', there seems to be reference to women being overly responsible for most areas of life. However, the way they might manifest is different. This influences the way YM develop their sense of self and roles within the world, which can influence the way they perceive their self-worth and MH based on their gender.

ii) *Expression of Emotion:*
There is a recognition in these narratives that show how difficult it is for men to express their emotions, the expectations that are required of them when it comes to expressing emotion, and the stigma that is tied to expression of emotion. There is a normalising of women to express emotion, however men are expected to be able to handle the difficulties they face. Here, there are excerpts that relate to the gendered expectations of demonstrating emotion between men and women.

With women it is very normal to share your problems with everyone, with other women, whereas if its men god help them because they never share it with anyone. (Layla)

The boys are not really allowed to express themselves in terms of their emotions … there's a lot of stigma, boys are seen as weak or they're seen as overly sensitive, not upset, or distraught. (Zahra)

With men … they have to take everything on the chin as we say and just get on with it and they keep everything contained. (Yahya)

Especially men they're always supposed to be really strong figures because if a man cries it's like they are weak … I think pretending is something in our culture that we

have to do ... I don't think this is in a religious way … but like it's our cultures and traditions that have really made men strong and they're not allowed to cry (Fatiha)

There is a norm around women being able to talk and express their emotions – as shown in Layla and Yahya's extracts; whilst there is a difficulty for men to be able to showcase their emotions due to many pressures. These pressures include, not being allowed to express emotion, the stigma of being perceived as being weak or sensitive, being expected to hold their emotions without expression and to not share their experiences. Fatiha interestingly referred to religious and cultural expectations in the gendered expectation of expressing emotions. She commented on this not being due to religious factors, but rather the cultural aspects that are linked to the portrayal of emotions in men in society, such as being 'strong' or being 'weak' if they cry. This highlights the way MH perceptions are developed as there are internalised gendered expectations on how to express emotions.

4.3.1.1.2 Conditions of Worth:

The expectations of culture for these participants' are demonstrated through aspects of their identity. The development of MH perceptions is an integral part of the YM development of identity. There is a weight of expectation that removes and challenges who they are, as they are not able to be themselves, but rather have to be something else (as shown by the subcategories above). There is an enquiring around what they are being valued for, and if these values are not present, then their value is questioned. Below, there are quotes from the data that highlight YM experiences of their struggles with where their value is placed.

There's a higher expectation on women to look great be educated be successful and if you're not successful or educated then at least look insane … and there's an expectation on men to be successful and to provide and to be happy and resilient all the time to not show any form of sadness or worry or stress. (Zahra)

There is also the obsession with skin colour … the fair skin gets more value as you grow up, fair skin girl gets more value. It always getting questioned like oh I wish you were a little bit more fair … I wish you know you had my colour. (Affiyah)

I think it was hard and a lot of pressure was always put up for me and I was always told to do better … sometimes it will frustrate me because I always think why do grades really matter like I wish they could see me for who I was actually who I am. (Fatiha)

My eating disorder began through how others perceived me and their comments of me and I think that's always something ive struggled with, how others are always very critical of my appearance. So that's something that really affected because I still thought I was being modest whereas family thought I wasn't and that kind of made it really hard for me. (Layla)

In Zahra's narrative, she explained the pressure of aspiring for success, and should that not be the case, then a woman needs to focus on her image. Men on the other hand are expected to also be successful, yet not be able to express what might be considered 'negative emotions'. The focus on image was also present in Affiyah's extract whereby she mentioned fairer skin colour as having more value and being reinforced by close family members. Affiyah also highlighted the challenges that are present in focussing on body image, in that value is placed on ideal body types, whilst being shamed, resulting in a sense of loss and confusion. Fatiha explains her frustrations about the pressures that she faces to succeed in academia, acknowledging the disparity between religious and cultural expectations. For Layla, the criticism she received about her images from family members influenced her relationship with body image and her relationship with food. This was also met with the differing perspectives of modesty and the criticism she received if that wasn't aligned with her wider family. There is commonality between these narratives that express a duality between what they may want to be valued for and the cultural expectation of what they should be valued for.

4.3.1.1.3 Expectations from Dual Cultural Identities:

There seems to be a lot of policing over the Muslim participants' ability to uphold a sense of authenticity for themselves, as they are attempting to justify their sense of belonging in various contexts. There seems to be a compromise that occurs between trying to maintain a sense of authenticity and to belong that are difficult to have simultaneously. Each cultural context requires a sacrifice on an authentic aspect of the self to belong to one social group, which then gets switched when faced with another group. This along with the frustration that can come with the individuals' identities being brought to question without the consideration of the balance that they are trying to preserve. The extracts here show experiences of YM navigating three components to their identity: religious, cultural, and British identities.

I'm an Algerian, but I'm raised in London so there's two strong cultures that are brought together. In the Algerian culture you've got the religious aspect but also

> *the traditional aspect. Then you've got the London culture …which is you have to be like this otherwise you won't be accepted in society.* (Yahya)

> *It always seems to be like a criticism whether it be a religious criticism or cultural criticism … I've had people say to me oh you're really whitewashed. I'm just not purely from one culture like how do you expect someone that was bought in the UK and has Pakistani family to live in a country like the UK and just have Pakistani values and traditions and ways of doing things?* (Zahra)

Yahya identified being Algerian, raised in London and being Muslim, and having to navigate those aspects of himself. Interestingly, Yahya comments on his Algerianness bringing along with it a religious side and a traditional side that he is expected to sustain. Further to this, Yahya is required to consider the culture of London and navigate a way of incorporating all these nuances into his sense of self, to avoid the risk of not belonging.

In Zahra's narrative, she explained a paradox in interlinking all parts of her identity, whereby her sense of belonging is monitored using criticism. She talks of the complexity of holding a Pakistani ethnicity, being raised in the UK, whilst not being able to truly fit in either one. There is a condemnation that comes with not being Pakistani 'enough' and an invisible nuance to what it involves to truly belong. Zahra expresses frustration in the expectation for her to hold no Western values when she has been exposed and influenced by the UK and that is an active part of her identity.

Both these narratives define the complexity that YM experience in attempting to assimilate themselves fully into all areas of their identity. The complexity is present in the ways that the participants' are expected to negotiate various aspects of their self and compromise their authenticity for the need to belong. However, find themselves in a position where their belonging is contingent on the approval of others.

4.3.1.2 Subcategory 2: Generational Guilt

The second subcategory that was recognised from the data was **Generational Guilt**. Some of the participants' expressed challenges that they faced in navigating expectations from family to *Uphold Cultural and Religious Values,* along with *Resistance to Change* in the older generations. These concepts significantly influence one another as the need to maintain

cultural and religious values can often intensify the resistance to change, or resistance to change can be due to wanting to uphold cultural and religious understandings. These perspectives may differ between generations which will be explored further below.

4.3.1.2.1 Upholding Cultural and Religious Values:

There is an expectation from families and society to ensure that YM uphold and maintain their cultural and religious values. Alongside this, there is an expectation to take ownership of group values as an individual. There seems to be a preference for certain aspects of identity like their cultural background and/or religion to remain attached to their inherited familial background.

> *If the parents are first generation immigrants because they're in an English, White, Christian country and so they try their best to kind of ensure that their kids stay on the right path, quote on quote right path, whatever that is, but as in to follow religion, to not forget their culture, to not be too whitewashed.* (Layla)

> *My parents, they've always said … we'd rather you'd be good Muslims than be high, mighty and successful and lose everything like religion … the idea that being a 'good religious boy' and an expectation that you shouldn't bring shame to your family … it's very hard to escape from and be individual, because you feel like anything you do reflects on your family.* (Nasir)

There is a similarity between Layla and Nasir's extracts that acknowledges them coming from a strict background. For Layla, she highlights the many layers that she holds and balances. She explains the familial expectations that need to be considered, from the impact of immigrating to a country that differs ethnically and religiously, whilst having to maintain the values of her inherent culture and religion. There is a process that requires effortful thinking even regarding being the 'right amount' of each social identity, such as her ethnicity and being brought up in the west.

Nasir similarly explains the importance of upholding religious values and demonstrates a familial and cultural preference towards sustaining religion. However, this seems to be closely interlinked with a sense of shame if this was to be rejected. The focus on religion is compared to societal success, suggesting that they are not compatible with one another. He comments on the difficulties of becoming independent from a culture and family, emphasising a pressure that any decision that he decides to act upon, ultimately has a consequence that directly

impacts the family. This seems to limit the ability for him to be seen as an individual and separate from his culture and family.

> *It's transferred from the older generation onto the younger generation like if I come across another Somali person I don't want to talk about tribalism with them I'd rather talk to them about for example if you start talking about back home then it I don't want to go down that path cause I don't want to talk about that I don't want you to ask me about what tribe I'm from or what tribe you're from and sometimes it's nice to talk about back home without getting into critical issues.* (Rabia)

Rabia discussed the challenges that arise when there is conflict occurring in home countries and the way this is then expected to be part of the normal discussion to establish what areas in Somalia individuals come from, and for this to define the conversation. She mentions this being expected generationally, particularly between people from Somalia. Rabia expresses that she does not want to be on the receiving end of those conversation or contribute to them as they are political in nature and would prefer to have other discussions about Somalia.

> *I was born into a Muslim family cause mum, my dad actually isn't Muslim he used to be when I was very small, I would say three or four I think, that's when he became an atheist but my mum is a practising Muslim prays her namaz five times a day, other than my dad everyone else around me is Muslim in my family, so I've been brought up in a very mixed house household of sort of very strong atheist but then my mum who's very strong Muslim female woman and yeah I do my namaz, I pray, I am a strong believer*. (Zahra)

> *My auntie definitely, every time we used to go to her house would always talk about religious things and she'll always try to educate us. I think she also knew my dad isn't religious at all so she thought I think, she thought, oh I should really make up for the things like he's not telling you which she did.* (Zahra)

Interestingly, Zahra grew up in a family where her dad became an atheist whereas her mum was a practicing Muslim. Zahra herself mentioned being committed to her religion and her religious practice that was put forward as an example by her mum. However, in addition to her mum, her aunty took responsibility in teaching Islam to Zahra as her dad was not involved in that process and so her aunty filled that gap to discuss religion and the values pertaining to Islam. In Zahra's narrative, safeguarding religion was important for her family, even though her father was not a Muslim and was something that Zahra also found important to maintain. The

YM explain ways that they are encouraged to represent themselves as individuals in a way that benefits the collective which influences their perspectives.

4.3.1.2.2 Resistance to Change:

There seems to be a disparity between older and younger generations in their expectations of YP and their outlook on how to cope with life's challenges. The challenges seem to lie in respecting the elders and their efforts, whilst balancing personal context and perspectives.

> *People still expect the same things that their parents expected in their generations, or their grandparents expected in their generation … cultures have to adapt to that, if they don't adapt to that you'll find clashes. For example, before families were very close together because they all lived together and now there's a distant relationship with families so it's not going to be the same as it was with how their parents were or how their grandparents were* (Yahya)

In Yahya's extract, he describes an assumption that all generations regardless of different location and cultures, are required to maintain similar norms to the previous generation. He expresses a frustration that comes with that, as he explains that a resistance to change can result in conflicts arising because of this friction. He explains the difficulty in navigating expectation in generations, from parents to grandparents, along with adhering to individual preference, and how there may be an undesired outcome regardless, such as disappointing another person, or not aligning with the self. He provides a solution which is to adapt cultural expectations to fit current circumstances and to update the beliefs for that to be an acceptable part of the process of change.

> *I try and explain it to my mom like my older aunts and people but they're just like why is it something that only people today, we also went through all of those things, and we didn't make it such a big deal …. I felt a bit like what am I supposed to believe in because the elders are people who teach us, but they don't believe in this but then I'm feeling all of these things which actually exists.* (Fatiha)

Fatiha reports her process of explaining difficult emotions to her family members. She explains the response that she is met with, that highlights the generational difference, where it is perceived, that mental difficulties were not in existence and people persevered through their given circumstances. There is a contrast in experience as there is a normalising of going through difficulty and potentially minimising/ observing differences in opinion. Fatiha explains

the battle between acknowledging her feelings, whilst facing external opinions that do not consider her experiences as a reality. By Fatiha sharing her experience of doubting her own feelings, she demonstrated a duality between her internal and external world.

> *My grandparents and my parents had to go through a lot for me to be happy and healthy alhamdulillah, so I think they've definitely instilled this 'just get on with it' culture … in the fact that things aren't always going to be fair, but you've just got to push on and carry on.* (Zahra)

Zahra provides a different outlook as she explains understanding the process that her grandparents and parents went through and acknowledges the impact that this has on her. She explains that there is an expectation to push through hardship. This differs from previous extracts in that there seems to be an acceptance and a conformity with what is expected of her, from her family. The reason for this acceptance is an understanding that there will be elements of life that feel unjust and to overcome that, you need to continue through it. This is different to Yahya and Fatiha who experience a contradiction in what they want and what is expected from them, whereas for Zahra there is an acceptance. These experiences suggest coping mechanisms for life's challenges, which influence the different ways that YM develop their MH perceptions.

4.3.1.3 Subcategory 3: Perspectives of Mental Health

The third subcategory that was identified in the data is **Perspectives of Mental Health.** Participants' underwent various experiences that contributed to their perspectives of MH demonstrating the *Cultural Barriers* that arise, the way that *Shame and Self-Blame,* and the *Invisibility of Mental Health.* This will be explored further below.

4.3.1.3.1 Cultural Barriers:

In this section, cultural barriers demonstrate the ways that MH can be perceived, understood, and referenced by people from the community. Cultural barrier refers to there not being the same understanding when talking about an issue that has arisen, for instance MH perceptions, which differs between cultures and the way it is received. This is due to cultures having developed their own outlook on all aspects of life such as MH, the way that there is limited language available to describe MH challenges, the way MH is viewed and accepted, and the

meaning that is made from having MH difficulties. For example, viewing MH through the lens of possession, evil eye and/or lack of faith.

> *Mental health is just very misunderstood; it's just looked at in such a weird way and this idea that it means a lack of faith which or it just means a lack of trying hard enough for a lack of effort… it's like a dismissiveness of it all.* (Hawa)

> *The way I've been told about possession, it's always because you've done something wrong or you've kind of brought too much attention to yourself so you get the evil eye, where through jealousy evil things can happen.* (Layla)

Here, Hawa and Layla discuss the way that MH referred to and made sense of. For Hawa, she explains that MH is not understood and is instead viewed from the lens that an individual has a deficiency, be it in their religious beliefs or their efforts towards increasing their level of religiosity. She concludes that there is a dismissal of the severity of MH outside of this understanding. Layla further comments on the concept of possession being a consequence of self-infliction, either through inviting attention to oneself that results in others being envious, therefore, evil eye and possession occur.

> *If I was to tell someone here how they would diagnose a person like that they wouldn't know they wouldn't think its jinn or possession or anything like that, unless they had some sort of spiritual belief … Someone who is fine one second and then they can get depressed maybe they can get depressed from evil eye or maybe they're normally depressed but here at the mental hospital they don't talk about the spiritual beliefs.* (Rabia)

In Rabia's account, she talks about the process of navigating the duality of the medical and religious/ cultural understanding of MH. Rabia comments on the challenges that may arise diagnostically in these differences, where in the West, possession and jinn may not be acknowledged as a possibility, rather there is a diagnostic process that occurs. She further explains how this is distinctive from her cultural and religious background where possession can be the cause of depression, and the difficulties in differentiating between them or observing them as a cause and effect. Rabia acknowledges the discrepancy in hospitals lack of consideration for spiritual beliefs, demonstrating the internal containment of dualities.

> *If someone has got anxiety and they're feeling anxious, or they're feeling panicky, they would use certain words like 'kabrat' which basically means I have warmth in my chest and so that could be heartburn. If someone's stressed, or really depressed*

> *about something they would say 'I have tension in my head' and so I would grow up thinking oh they've got a headache, but no its not, it means they're depressed.* (Layla)

> *So, when I was growing up like my parents used to use a phrase 'faghul' it meant crazy in Bengali, and it meant crazy in the sense of like that person is deranged they should be in an asylum or something like that. There was no sense that that person mentally unaware in the sense that they're sad.* (Nasir)

Layla and Nasir comment on the ways that there may be a language difference in the cultural understanding of MH. Layla explains that the language that is used to describe MH difficulties has an incongruity to the experience. She describes that the terminology used to describe the medicalised concept of anxiety, is understood through physical symptoms that also relate to physical health issues like heartburn. She clarified the numerous meanings that can come under a word, having different connotations depending on the situation. She also explains the process of navigating the literal sense of the word and what it has been substituted in for, adjusting the way she made meaning of the words as she developed.

Nasir describes terminology that was used in Bengali, that suggests that, rather than MH being on a spectrum, there is a strong narrative that MH is something to avoid and has quite disturbing imagery of what MH might look like. Nasir notes that there was no range to what constituted MH, rather there was a particular description that influenced his outlook on MH difficulties. This description involved a person being severely disturbed, resulting in them being institutionalised. The participants' highlight how MH is not always understood and can be attributed entirely to concepts within culture and religion such as possession. This impacts the way that MH perceptions are developed in YM, the nuanced ways of understanding MH and the dualities within them, through language (what is being said versus what is meant), religion (faith versus lack of faith), and culture (evil eye versus western ideas).

4.3.1.3.2 Shame and Self-Blame

This subcategory highlights how MH can be perceived by the self and others. This can include the self as weak and societal stigma. The shame that is discussed in this section refers to the emotion that is determined by the thoughts, feelings, and behaviours of others that results in negative self-evaluation, or for individuals to conceal and negate their experiences. For instance, the way that MH is to be kept concealed and masked which can impact the way

perceptions are established. This along with experiences of self-blame which is the way people attribute a difficult situation onto themselves and that has implications such as being seen as 'weak'.

> *I actually thought it was your weakness or your inability that you are facing these problems … it's you who is incapable of controlling your emotions and that's the reason it happens.* (Affiyah)

> *It's like the social stigma that's attached a lot to masculinity and feeling like you have to be like this strong male, and you shouldn't be sad … mental health is something that, I associate it with weakness, even I do …I kind of think well if I'm feeling like this then I'm weak, so not feeling like it is strong …. It's those kinds of feelings as well like stigma and shame.* (Nasir)

There is a commonality between these two perspectives, which is that suffering from MH difficulties is a sign of weakness. There is indication that it is self-inflicted and that there is a fault in their capacity to cope with the challenges they are facing. In Affiyah's extract, she speaks of the challenges she faces being caused by not being 'strong enough' to face them. There seems to be a self-blaming outlook that demonstrates a criticism of the person going through the difficult situation, not showing compassion to the self.

For Nasir, he explains the stigma that is linked to masculinity that suggests that a man is not allowed to experience difficult emotions, and consequently it is a sign of weakness. He speaks of his experience with MH, whilst maintaining that it is a sign of weakness and something to be hidden and concealed. He further notes feelings of shame, demonstrating the complexity of his experience. Nasir's experience seems to be layered, from experiences of personal challenges, to managing social stigma, own stigma, and the impact that it has on behaviour. It is interesting to note that there seems to be an association of MH as a weakness from both genders.

> *There is a lot of stigma and a lot of misunderstanding of mental health it's something that's hidden within culture, and I don't think that it's something that is encouraged and is promoted … the relationship between culture on mental health is a very hidden and secretive, bury your head in the sand don't talk about it keep it within your homes.* (Ahmed)

Ahmed comments on the stigma and judgement that occurs once a MH difficulty is disclosed. He speaks of MH difficulties not being appreciated for their challenges and something that needs to be kept hidden and secretive. This is like Nasir's explanation of his own approach, however, for Ahmed, he is explaining a wider familial and societal approach to concealing MH. There seems to be a denial of MH challenges and a requirement to disguise it from society. Ahmed explains this through secrecy, and ensuring that it is kept contained within households, suggesting that it is not to be discussed externally. This contributes to the way MH is developed and perceived by YM.

4.3.1.3.3 Invisibility of Mental Health:

The way that MH was present in participants' lives highlights a lack of awareness, dialogue, and belief about the existence of MH and what constitutes MH difficulties. Below are extracts that discuss the way in which MH was learnt about in their life, and the way in which it was considered in their development.

> *I've never really discussed this topic at home as I don't think anybody would really believe in it as much.* (Fatiha)

> *I never really learned about mental health, actually a lot of people especially people from ethnic backgrounds and stuff, like all they're told is man up, be strong, get through with it.* (Yahya)

> *It's often not considered, you know, you often go to hospital, for your body but it's considered a part of your body as well but sort of a lot of people don't consider it physical ailment, but it definitely is a physical ailment.* (Zahra)

One of the similarities between these narratives is the lack of discussion around MH. Fatiha explains that in her experience there wasn't talk of MH within her home around MH due to it not being something that would be deemed a reality. Yahya speaks to not having learned about MH, and if something does arise, there is an expectation to push through which, granted, may be useful to some, but recognises that it is not a one size that fits all. Moreover, Zahra compares the treatment of MH to physical difficulties and suggests that MH difficulties is a physical disorder that needs to be treated as one. This further suggests that MH has an invisibility in the experiences of YM.

> *I knew about mental health and mental well-being and mental health conditions, but I wasn't too concerned with it because it wasn't something that I was involved with and I sort've didn't respect it enough in that sense.* (Ahmed)

> *So, it was never really spoken about like having depression or anxiety or any of these other things, but it was just like make sure to look after yourself and take a break between studying and that sort of thing.* (Najia)

On the other hand, these extracts demonstrate an acknowledgement of MH well-being and challenges as being something that existed, but perhaps was not obviously present in their daily lives. Ahmed reflects that he was aware of MH, but it was not something that he paid close attention to or took seriously. Najia reports a more subtle experience where there was a nod towards MH well-being and ways to maintain that within an education system, however MH conditions were less known about and acknowledged. In Najia's account there seems to be a hint of MH, but perhaps a lack of clarity to what is involved. This shows the presence of MH in their lives and the way it was acknowledged by themselves and those around them.

4.3.1.4 Subcategory 4: Affect

The fourth subcategory that was recognised from the data was **Affect** which explores the emotional consequences of **Navigating Complex Multiplicities.** Many of the participants' expressed the way their experiences had resulted in a sense of *Belonging* and/ or lack of belonging along with *Social Denigration.* These will be explored further.

4.3.1.4.1 Belonging:

There is a recognition that a YM' sense of belonging can be impacted when balancing their dual cultural identities. This is alongside needing to be accepted by the cultures that they belong to and the way this is achieved can be perceived in many ways. Below demonstrates the way YM sense of belonging can be a positive experience, whilst also highlighting the challenges that are present in their ability to be able to fit in.

> *It's a sense of belonging, I love the idea that when I'm doing something … that around the world thousands and hundreds and thousands of people are also maybe doing that like making Samosa's in Ramadan* (Hawa)

> *I missed out on all the good things that culture does bring like that sense of community and that sense of actually belonging somewhere.* (Najia)

> *I think it helps me to fit in, I can recognise myself within a group of people I think without my culture and without my South Asian background … I think my culture brings a lot of colour and a lot of fun and enjoyment within my life and in my personality as well.* (Ahmed)

There is a recognition that culture can bring a sense of belonging to a community that shares a similar practice. Hawa describes culture as providing her with reassurance she is part of a global community that engages in the same religion, participating in cooking similar food for that time of the year. Najia also acknowledges an aspect of culture that could offer belonging; however, she speaks of not having had the opportunity to have that experience. Ahmed goes on to explain the way his culture allows him to feel like he belongs, as he explains that there is an integration of culture within his personality and provides him with the ability to recognise himself amongst others. He speaks of the vibrancy that culture gives him, impacting his behaviour and the way he views his personality to be exciting and colourful.

> *I am a massive social chameleon … it's like because you chop and change, you can never really be, not genuine but you can never feel like settled in like one place.* (Nasir)

> *It's difficult because at home you're a person who has a culture that you have to adhere to and then as soon as you step out the house you've got another culture that you have to adhere too and sometimes they might clash and when it clashes they've got like the cultural differences to please at home and then at the same time they got the cultural differences outside which affects the way people act.* (Yahya)

> *Growing up like we were kind of first- or second-generation immigrants that it's like you are automatically different and you don't quite fit into British culture itself and you fit into no culture because you're not part of anything.* (Najia)

The above extracts explore the notion of these participants' navigating their sense of belonging in a community, whilst considering their own sense of self. They describe the process of not fitting in because of a few reasons. For Nasir, he comments on being a 'social chameleon', indicating a process of constant change of self, due to not being able to be his entire self in one situation, compared to the next. In his narrative, Nasir comments on how the way he talks changes depending on where he is, differing in his accent perpetuating his sense of belonging.

Similarly, Yahya discusses the way that being at home and outside have varying prerequisites, for instance, at home there is one culture that has expectations to be fulfilled, and then to go outside, there is the British culture to conform to and they both have their own differences. These differences can be conflicting in nature, yet there is the need to entertain each of the cultural elements depending on the setting, which for him has an effect on behaviour.

Najia further reports that her sense of belonging is impacted as she doesn't fully fit into being British as she is first – second generation immigrant. She highlights the impact this has on her, as there is an automatic process that happens where her parents have immigrated to the UK, resulting in Najia's experience of not fitting into any culture.

> *It's a Pakistani British hybrid … it's like lots of dancing, joking around family community from that sense of belonging that often Pakistani or any non-white person in the UK feel doesn't really have.* (Zahra)

> *It just made me feel reduced to a culture that I don't actually belong in it's almost like oh but you're white but like no I don't even fit into white culture … it's almost like the place that you just find belonging in is like saying no you're too much like the place that you don't belong to … you go to what you see is your homeland and they consider you as too white to be there but when you go home to here you're too brown do you know I mean.* (Zahra)

Above are two extracts from Zahra's narrative, one being a positive outlook on culture, and the other being negative. This has been included as it is important to demonstrate the nuances and dualities in the experience. Zahra mentions her being a hybrid, which is a combination of Pakistani and British and the interaction between the two. She explores her sense of belonging to her community, describing the aspects of culture that she enjoys, understanding that this may be unique to her culture that not many get to experience. There is the focus on family and community as the main areas in which belonging is established.

On the other hand, Zahra explains her experience of being grouped into a culture that she does not identify for herself by others. Zahra alludes to feeling being limited to one culture in which she finds she doesn't belong to that doesn't encompass her experience and is being initiated by others despite her experiences being very different. She explains a sense of rejection where

the culture she feels she identifies with is refusing and redirecting where she belongs. Zahra interestingly explains how her belongingness is commented on when she visits Pakistan as she is identified as being predominantly British. Then, when she is in the UK, she holds both her Pakistani and British identity, however, would be viewed more as Pakistani than British. It is as though there is a pendulum effect where the lens through which she is viewed by others depends on her context and the people she is with.

4.3.1.4.2 Social Denigration

The concept of judgement was recognised and described by the participants'. There seems to be a judgement that is placed on people according to their circumstances, having an impact on the YM. The experiences demonstrate judgements and criticisms that the YM face through the various circumstances that they are in. The next excerpts demonstrate the young Muslim's experiences of judgement and how it presents in their lives.

> *There's also a lot of people like a lot of judgement of people their position their wealth the education factor their role in society.* (Ahmed)

> *There's a lot of judgement on like just how you live your life in general. It always seems to be like a criticism whether it be a religious criticism or cultural criticism.* (Layla)

Ahmed and Layla note the ways that judgement tends to be used is dependent on the status, position, religious or cultural choices of a person. Ahmed explains that value is placed on certain positioning that a person holds, usually in the form of wealth, education, and career. Layla adds that her experience of judgement materialises in an analysis, then a censure of an individual's religious or cultural practice.

> *Everyone is aware of each other and so everyone knows each other, and people really judge you.* (Fatiha)

> *It's the judgement that can come from like my parents' divorce, like a lack of support because of worry about what people will say because culturally people will think that is not accepted like religiously is allowed but culturally it might not be.* (Hawa)

> *The more I've grown up the more I disregard the community here, because I'm like what does this community to for me as an individual you know, if there is that element of judgement and shame and gossip.* (Nasir)

In Fatiha's extract, she explains the complexity of navigating judgement as she summarises that there is a close community where people know each other and make judgements of one another. Hawa described how her parents had gone through a divorce and the judgement that came with that. She explained that they did not experience support due to concern around the judgement that would come with disclosing their situation. She further notes how she is balancing the knowledge that divorce is acceptable religiously, but culturally might be disagreeable and the way that this needs to be navigated. Whereas for Nasir, it seems as though he separates himself from the community, considering the benefits of community to him as he experienced being judged. The YM describe the prevalence of judgement in the community around certain experiences which results in them feeling unsupported and/or leads to behaviours of separation. This further highlights the way that challenges that are faced by YM is treated and understood, impacting the way they develop their MH perceptions.

4.3.1.5 Subcategory 5: Individual Discovery

The fifth subcategory from the analysis of the data is **Individual Discovery.** To establish their own sense of perspective, Muslim YP went through a process that allowed them to identify their stance on certain situations. This is not a straightforward, linear process and can have nuances and obstacles that include navigating their own beliefs, along with that of their parents and community. This is explored further below.

> *We grew up in a predominantly Christian country and so we had to explore religion for ourselves, whereas if we were in a Muslim country, it would be kind of your brought up with it, so you already know about religion, so I think for me, I kind of made my own sense of what religion is to me.* (Layla)

> *I know the reasons behind why I do most of the things and if I don't understand it then I would obviously go ask them or look it up. I guess there's a lot more deeper meaning now than when I was younger … i guess they taught me the basics and I've sort of like strengthened the foundations.* (Rabia)

Here, Layla and Rabia discuss the ways that they have developed an understanding of their religion from the way they observed it growing up. Layla describes the way that she began discovering religion by showcasing the difference in upbringing to her parents and the ways this may have been different, such as the limited exposure to the same religion on a societal

level. She explains that growing up in the UK required her to seek knowledge about her religion independently, because if she had been raised in a Muslim country, the prerequisites of the religion would already be established and understood. Layla went through the process of discovering religion for herself in and amongst her culture. Rabia explains that she understands the reasons behind her beliefs however, if she doesn't then she will extend her knowledge on the topic. She describes that there is a more internal strengthening of her beliefs, compared to an external difference in the way she and her parents practice.

> *I think by having a strong understanding of my religion is sort of helped me to appreciate what is what type of support I do need on what type of support I'm probably better off not having.* (Ahmed)

Ahmed encountered challenges during that time that led to him distinguishing between religion and culture and learning what Islam promotes in relation to MH. He discusses the way that this has allowed him to recognise when advice is in accordance with Islam or his culture. It seems that if something is in line with Islam, then it its observed, whereas if the advice has stemmed from culture, he might reconsider what is being suggested. This shows that there is a process of individual discovery and the development of his MH perceptions that explores elements of religion and culture that fits in with his outlook and personal consolation.

> *There's a big difference like culture is very restrictive … but I get to decide if I am going to implement these things or not … I'm doing it for my relationship with my religion and for my belief and Allah.* (Hawa)

> *The first thing that comes to mind is the word 'restrictive' … I feel kind of suffocated, there's a lot of stuff in my culture that make, could make one feel kind of like they're closed in in a box … I often find freedom in religion; I feel like my religion makes sense.* (Layla)

Hawa and Layla share a similar perspective on culture, describing it as 'restrictive'. They find a level of freedom associated with religion that allows them to implement their beliefs into their lives, in a way that gives them choice. Hawa comments on the way that there is an expectation in culture to implement religion in a way that has been conducted previously, however religion allows room to practice in the way it is understood individually. She observes that there is an element of shifting purpose and reason for implementing religion, from being told and encouraged by others, to being implemented for the self. There is an internal shift that occurs

whilst also working within the boundaries put forward by Islam, as opposed to the wider cultural and traditional way of practicing religion that seems to be restrictive.

Additionally, Layla speaks of the way that culture feels enclosing due to suggested practices and expectations that feel obligatory as opposed to optional. She explains the difficulties being connected to customs that are expected to be implemented in a particular way. Alternatively, Layla finds liberty in religion as it is something that doesn't seem to contradict with herself that is expected for her to follow. The participants' highlight a process of discovering and prioritising what feels important to them and the outlook that they would like to have by assessing the messages that they receive, and how it aligns with them. This contributes to the development of their MH perceptions as they are determining the lens in which they want to view the world.

4.3.1.6 Subcategory 6: Resources in Religion

The sixth subcategory that was identified in the data is **Resources in Religion.** When a Muslim goes through life, and experiences hardship or is seeking guidance in life, they may turn towards religion. Most, if not all Muslim YP found that there was supportive material within their religion that they found useful and important. The following quotes demonstrate this:

> *I like to memorise certain bits of the Quran and use that in my salaat because for me good quality salaat helps me …. I can use my own voice and within my own self, recite it and use it in my prayers which is soothing and even helps me de-stresses me and gives me hope.* (Affiyah)

> *Praying for me and reading Quran and mostly reading stories of the prophets like some of the stories like you can read about their hardships and how they kind of came through them and ask Allah for help.* (Hawa)

> *If I'm in situations of stress or like if I'm cornered or if I feel like pressure or like cornered, almost seeking out religion or like God for the help, support.* (Nasir)

In these extracts, there is a similarity in that the recitation of the Quran seems to be an act that helps these YP destress and be provided with peace. Affiyah describes her attempts to memorise the Quran as being beneficial, in terms of melodiously reciting the Quran and its implementation into her prayer. It seems that her connection to the Quran allows her to have many uses that provides her with a strength, aid, and hope. She depicts the Quran to be an aspect of her religion that she can develop a quality of practice, that allows her to incorporate

it with her prayer, which seems significant for Affiyah. Hawa similarly explains that prayer and Quran are helpful for her. This in conjunction with learning about the stories of the Prophets that provide her with examples of how they overcame their difficulties. Nasir comments on turning to religion in times of stress where God is sought after for support. These narratives provide an insight into the way that religion is used to provide a sense of peace along with tools to overcome difficulties that they are facing.

> *I would describe religion as peaceful, I think of it as being like the medicine for life ...I think it has a lot of benefits to it for health and if you have any problems, you can go to the Quran, the book or pray to God, so religion for me is peace and cure. The cure basically.* (Layla)

> *There is scientific proof to that that when you make prostration to the ground, how much stress that that relieves … that if you were to stay in that position for a couple of times today than it would already release and bring your blood pressure lower … The Prophet (saw) used to have worries or anything like that, he used to go and pray 2 rakats, for me that is the best thing to do … Islam gives the answer to all of these types of problems or anything that can root to mental health and it tells you if you've got a problem then you go through the Quran.* (Yahya)

There is an embodied experience of religious practice that is present in the YM experience, along with being connected to medicinal and health benefits. Layla connects religion to providing her with a sense of peace, along with being a form of medicine for her. Medicine can often demonstrate a substance that eases or prevents diseases, which demonstrates the way that Layla connects to religion. She explains turning to the Quran and prayer as a treatment to difficulties that she faces. Yahya further explains the connection between scientifically proven ideas to justify the benefits of prayer, especially in prostration which religiously is an important aspect of prayer. He emphasises the health benefits to these acts of worship, along with the religious important of mirroring the Prophet's (peace be upon him) behaviour in times of hardship. Yahya implores that religion provides a direct remedy to MH, which are referenced by the Quran as a source.

> *Really long dua's after prayer really helped me especially if I've done like from my own language … it somehow feels like someone is listening to everything without judging … read dua's in Arabic meaning on there somehow dedicated to helping anxiety and stuff and I sometimes read those and reading Quran as well when I feel low.* (Fatiha)

You can make dua whenever … we believe in qadr, like predestination. (Najia)

There seems to be benefit found in dua's, which are supplications that can be done outside of prayer, along with inside prayers. Fatiha acknowledges supplication as being beneficial for her particularly when connecting through her first language, whilst giving her a sense that she is not being judged. This alongside reading supplications that are specified in Arabic for anxiety and stress relief, and recitation of the Quran seem to be resources that she uses in times of emotional difficulty. Najia further denotes the significance of supplication, commenting on its ease of use, its accessibility, and the way it is encompassed in hopefulness. Najia also mentions predestination as being a useful resource to coping with situations that might arise unexpectedly to provide a justification and reasoning to overcome disappointment and provide understanding.

> *We have a way of meditating five times a day … when I don't pray for a long time that's why mentally I don't feel well and when I start praying things seem to get better whether it be an act of God easing our difficulties.* (Zahra)

> *With the salaat as well it sections the day out … when I'm not praying then you can see the difference and I'm a lot more lazier when I'm not praying, I see the day goes by a lot quicker and I don't have the sort of routine that I have when I'm praying.* (Rabia)

> *Reading our holy book the Quran as sort of giving me a step by step advice an instruction on how to live my life and stories about the Prophet (Saw) and his experiences in his life and his trials and tribulations has sort of helped me … certain dua's that I make in order to alleviate my stresses and put my reliance on God and there are certain prayers that are known to reduce anxiety or to make you more confident and I've learnt them off by heart and whenever I do get stressed or get worried, I do recite those prayers.* (Ahmed)

Religion seems to have a practical benefit to YM that provides clear guidance on what is expected from them. Zahra likened prayer to meditation that is readily provided throughout the day, noting that she experiences a difference if she has not engaged in prayer after some time. She observes the prayer and understands it as a way of God alleviating hardship. Rabia refers to prayer as a religious act that provides timestamps throughout the day that allows her to set up a routine that allows her to accomplish her tasks for the day. Like Zahra, Rabia reports on noticing a difference in her life when she doesn't prayer, experiencing physical difference

internally along with a change in the concept of time. Ahmed also finds benefit in the Quran as a guidance for how to live his life, along with reference to important religious figures who experienced challenges providing help-seeking resources for him. Ahmed also references religion for betterment of self and a guidance on how to conduct himself. He also finds benefit in performing prayers and reciting supplications for the alleviation of stress. There seems to be active methods that YM can implement into their lives, especially in times of difficulty.

4.3.1.7 Subcategory 7: Connection to Self

The final subcategory that was established from the data was **Connection to Self.** It was found that participants' go through a process of discovering aspects of culture and religion that they want to implement, along with the way in which they identify themselves. Some of the ways that this presents itself is in how the young person navigates their identity around their ethnic culture, their British culture and Islam.

> *I guess I just take the good from culture and leave the bad … I would say that my culture, if you can say that, is my religion. I try to adopt my religion into my culture, as my culture. I try to mix the two, I take the good from my culture and I take my religion and I put the two together.* (Layla)

> *I identify myself as British Muslim … like my identity is like who I'm trying to make myself right now rather than culture impacting it at all.* (Najia)

> *I just say I'm a hybrid like I do things in my own way in my own style … it's just not 100% Pakistani. At the end of the day, you have to put your religion above everything and if your religion says something and culture says another then at least in my family but you try to put religion above that.* (Zahra)

A negotiation and selection process seems to occur when YP are deciding on their identity and what aligns with their sense of self. Layla describes a process of adopting parts of culture that are positive and giving up that which doesn't fit. She also describes embracing religion as her culture, where she incorporates positive aspects of her culture alongside her religious practice. Najia purports her sense of identity is linked to her religion and being British. Her negotiation process seems to include identifying a lack of connection to her ethnic culture, whilst pinpointing her sense of self to who she would like to be. Moreover, Zahra mentions being an amalgamation of her identities. There is an acceptance of having many aspects to her identity that works for her. Zahra prioritises religion over culture, noting that if there is an incompatibility between aspects of culture and religion, then religion takes precedence where

informed decisions are made based on context. There is a selection process that happens to allocate aspects of what is known, to who they would like to be.

> *I'm a Muslim first before I'm Algerian or British … I'm a Muslim first because I feel like a Islam it gives you an identity and you can be British but how many different types of things is British adhered to or how many connotations does it actually have to be British so you can be a certain way, and same with Algeria, you can be this or you could be that, but there is only one Islam and that's my identity.* (Yahya)

> *I became a Muslim because I am a Muslim if that makes sense, I'm not just a Muslim by name … I follow the beliefs and I truly believe in my religion and that's why I am a Muslim … at home everything is to do with my eastern culture note my South Asian culture and then when I'm out and about so when I'm at work or when I'm in at the mall or anything like that I am heavily reliant on my British culture … So, my British side is not just that they are two separate bits, I am a British Kashmiri, is probably the correct title for me.* (Ahmed)

> *I guess one of the problems that I had was to try and find my own identity in being a woman in Islam and you hear a lot about the prophets (saw) and the sahaba and the companions and like being a woman in Islam … I guess that sort of helped me find my identity.* (Rabia)

In these extracts, the participants' acknowledge religion as centrefold to how they identify, whilst appreciating cultural influence as secondary. For instance, Yahya promotes being a Muslim as his primary identity as he suggests that his religion provides an identity that is recognised between Muslims as a foundation. He explores the way that culture, be it British or Algerian can have multiple nuances and definitions to what constitutes their identity which is more complex, whereas religion alleviates that sense of complexity for him. He explains Islam providing one sense of being, being applicable to anyone regardless of their cultural background.

Furthermore, Ahmed comments on being a Muslim through means that surpass the name, but rather is due to his conviction in his religion. He also describes the way that he incorporates his British culture and South Asian culture into his life. This is through implementing South Asian elements into his home life, then transitioning to his British identity when he is outside of the home. Additionally, he acknowledges being able to hold these aspects of his identity together and merge them allowing him to be Muslim, whilst being a British Kashmiri that denotes a

integration of his identities. In both Yahya and Ahmed's narratives, there seems to be a process of maintaining and fulfilling religious and cultural obligations whilst remaining in the UK.

Moreover, Rabia explains some obstacles in discovering her identity, particularly around establishing what it means to be a Muslim woman. She depicts the way the stories of the companions of the Prophet, particularly the women, provided her with examples of Muslim women and the way they portrayed themselves. This allowed her to recognise herself and connect elements of being a Muslim woman, to what she felt aligned with her identity. These YM highlight the ways that they have negotiated and understood their identities. They have suggested that their outlook is channelled through a dominant perspective that fits with their understanding of MH, where they receive support which alleviates some of the struggle in balancing numerous perspectives without a governing belief. This shapes the development of their MH perspectives.

4.4 Chapter Summary

In this chapter, the theory was revealed from the findings of the data. Overall, there was one main category that emerged from the data which is **Navigating Complex Multiplicities**. Within this main category, there are seven subcategories: **Expectations in Culture** which comprises of roles and responsibilities, expression of emotion, placement of value and expectation from dual cultural identity. The second subcategory was **Generational Guilt** which included upholding cultural and religious values and resistance to change. The next subcategory was **Perspectives of Mental Health** which encompasses cultural barriers, shame and self-blame and invisibility of MH. This then leads to the fourth subcategory, **Affect**, which holds a sense of belonging and social denigration. Then includes the need for the fifth subcategory known as **Individual Discovery** which leads to the recognition of the sixth subcategory, **Resources in Religion** and finally a process of **Connection to Self** as the seventh subcategory.

CHAPTER 5: DISCUSSION

This chapter will discuss the key features of the theoretical categories that were presented in Chapter 4 that had an influence on the emergent theoretical understanding of YM' MH perceptions. By gaining insight into YP's perspectives on their experiences with religion and culture's influence on the development of their MH perceptions, the processes that contribute to their outlook was revealed. The main category and seven sub-categories summarised below, represent a preliminary platform to enhance our understandings of the complex ways that YM navigate the processes that form the way they perceive MH, factoring in the multifaceted influence of culture and religion. The categories contributed to areas of clinical practice and CP, to enhance understanding of what impacts YP's experiences of MH, which will be detailed below. The limitations of this research will be explored alongside the implications this research has for clinical practice and CP, as well as suggestions for further research. An additional reflexivity section is included.

5.1 Summary of Findings

The theory generated from the data, revealed a process that YM people go through when developing their MH perceptions stemming from the central category labelled as **Navigating Complex Multiplicities.** This encompasses how YM understand and experience their perspectives within the numerous paradigms that they are a part of, which all have their own systems, policies, and diversity in the way they are incorporated into their outlook. This category implores the experience of YM in balancing the multiple dualities that are present in their life and how these all interact.

The theory that emerged from this research shows the many layers of culture and religion that YM are holding, which interact and often contrast with one another, contributing to their perspectives of MH. These perspectives vary between individuals depending on their personal experiences. This includes the interplay and cyclical nature between **Expectations in Culture**, **Generational Guilt**, and **Perspectives of Mental Health** and the existing dualities seen within these categories. The tension between the *placement of value* on the *resistance to change* in generations can lead to recognising the way MH is perceived. In this research, this was

demonstrated in the form of *shame and self-blame* and how there is an *invisibility of mental health.*

This brings awareness of their emotional experience **(affect)**, and where they are situated amongst these dualities, shedding light on their sense of belonging along with the judgement that they receive. This can provoke YM to embark on an **individual discovery** where the dualities become more prevalent and obvious to them, leading them to begin making sense of their positionality. The participants' begin to distinguish between religion and culture, leading to the discovery of religious perspectives on MH and struggle. Participants' may continue to value aspects of their culture, whilst recognising the dichotomy with religion in some areas, resulting in a negotiation process to which they **Connect to Self,** according to what they value.

5.2 Discussion of Findings

To begin conceptualising this research, the notion of duality needs to be addressed. The main category that was conceptualised in this research is **Navigating Complex Multiplicities,** which refers to how YM understand their perspectives in the context of numerous paradigms to which they belong. For example, dual cultural identities (British and Pakistani), religion and culture (Islam and Bangladeshi/ British), individualism and collectivism, generational and personal expectations, religious and/or cultural view of MH and medicalised views of MH.

The definition of duality in the Cambridge Dictionary (2022) is the 'state of combining two different things'. The concept of duality in cultural and religious research has often explored the dualities within either religion or culture, as opposed to the dualities between them. Dualism within culture has been explored around the idea of bringing together two distinctive cultural groups, such as being Korean and American (Song, 2009). Whereas duality in religion is the belief in two opposing beings that have created the world (Bianchi & Stefon, 2022). There has been acknowledgement of the relationship between culture and religion, particularly in human rights research which promoted the differentiation between them (Abdulla, 2018). This task can be difficult, as there are some notions within religion that have intertwined with culture, and some cultural ideas becoming religionised (Abdulla, 2018). Recognising the relationship between culture and religion can be useful in understanding their effect on one another and the way they can shape individual perspectives.

The findings in this research illustrated some of the challenges faced by participants', regarding the expectations they face from upholding their dual cultural identities and balancing this with being authentic to themselves. The participants' experiences impacted their sense of identity and need to belong within their communities. DuBois (2013) composed the notion of 'double consciousness' and developed a well-known piece: '*One ever feels his twoness – an American, a Negro – two souls, two thoughts, two unreconciled strivings, two warring ideals in one dark body whose dogged strength alone keeps it from being torn asunder.'* (2013, p.g., 17). This passage highlights the experience of cultural duality in Black Americans and the way that they embody, manage, and balance their identities. It provides an insight into the way that an individual can carry dual aspects of self, that can be contradictory yet bound to the individual within which these aspects reside. Additionally, the experience of cultural duality in the Caribbean community was observed, identifying the notion of 'socialised ambivalence' that exists within Haitian culture, which stemmed from two sets of counteracting principles and ways of being, such as African and European (DuBois, 2013). This demonstrates that there is often a difference between cultures, and what that means for the person managing the duality, the process they engage in and how they balance it within themselves.

Research was conducted in the Netherlands with Turkish Muslims who were seen to be connected to collectivist standards and promote them within their obligation to their ethnic in-group (Phalet & Güngör, 2004). The participants' demonstrated an in-group connection with their ethnicity and Muslim identities, perpetuating the absolutist idea of belonging to the groups as opposed to them being elective. Due to the governmental status, being Turkish, Muslim, and Dutch national was conflicting, as it suggested that there is a division between ethnic and religious affiliation with Dutch identification (Kreiner & Ashford, 2004). This was explained as a 'reaction or oppositional identity' (Ogbu, 1993, p.g. 1459) which refers to apparent social rejection and depreciation that could affect a sense of identity within the national group and increase in ascertaining only within the minority group (Maliepaard, Lubers & Gijsberts, 2010). An example of this would be being more Turkish and less Dutch or feeling Pakistani and not so British (Ali & Fokkema, 2015).

In *Expectations from Dual Cultural Identities*, participants' discussed the way that they are required to adapt, according to the social group that they are presented with. The participants' felt frustrated that their acceptance into the group was determined by others. Dual-identity in German Jews was explored by Mendes-Flohr (1999) who maintained that they were assimilated into the cultural ideals of Germany but were not embraced into the German society. The societal separation indicated an incomplete acclimatisation into the national German society. The process of acculturation, whereby there is a cultural adaptation when attempting to equal the effect of two cultures whilst adjusting to the dominant presenting societal culture (Cranier, 2022), that was expected from German Jews meant that there were variations in the preservation of Jewish identity, understanding and obligation (Ashheim, 2007). Acculturation does not mean that Judaism was forsaken, rather there was an impact on their identity, and cultural allegiances were ruptured, thus requiring them to face the obstacles of inhabiting a myriad of cultural associations (Cohen, 1997).

Findings of the current study indicated how YM's sense of belonging was affected by their dual cultural identities. On one hand, YMs found a sense of community in their socio-cultural-religious identities and the practices within them. However, they experienced difficulties fitting into one community, without consequently feeling like an outsider and/or they don't belong, which may impact their MH. Research shows that religious beliefs of Muslims influence the MH of individuals, communities and families and are an important part of their identity (Nasser-McMillan & Hakin-Larson, 2003). Research conducted on YP from many minority groups, such as religious, cultural, and racial, propose that discovering a community that allows them to be a member of the group and getting support from a group, allows them to develop a sense of belonging (Hannon et al., 2016). A sense of belonging to a community safeguards individuals from mental distress stemming from minority-related challenges (Grossman & Liang, 2008). Therefore, experiences that encourage promising social interactions can communicate a sense of recognition and belonging that can guard YM from the negative impact of discrimination, allowing them to adjust to their environment (Totonchi et al., 2022).

The participants' in the current research have also discussed their spatiality comparative to their parents and explored the process of differentiating their perspective from those around them. For example, many of the participants' delegated Islam as their primary identity marker,

signifying its importance in their identity. YM have been marked as problematic and threatening due to concerns around conflicting with supposed 'British values' and have been suspected to not be attached to the UK (Thompson & Pihlaja, 2018; Sales, 2012; Sadar & Ahmad, 2012). This applies to YM who were born and brought up in the UK as their 'Muslimness' is viewed as not British, with objectionable connotations to their religiosity and where their parents migrated from (Kapinga et al., 2022). The stereotypes about Muslims influence the way YM conceptualise, question, and form their identities using religion and culture, as they navigate their way to adulthood. In discovering their religious identity, YM may position themselves in accordance with locations outside the UK (Kapinga et al., 2022). As they begin to impart from their parents, they may distinguish a way of being Muslims from their parents' country of origin. Whilst this may be important for their cultural identity, YM may incorporate religious locations such as Makkah, to their Muslim identity. Thompson and Pihlaja (2018) show that although context is important, YM' religious and cultural respective identities can embark on varying paths which demonstrate the development of their religious characteristics and principles.

Moreover, there is a spectrum of religiosity and practice of Islamic duties. The YM in this research, added to this by explaining how their identities are often in conflict which includes being British, along with their ethnic culture and Islamic identities, and they feel required to negotiate between them. For example, this can be done by prioritising Islam, and thus engage in anything within their British and ethnic culture that aligns with Islam whereas anything outside the Islamic remit was rejected. Yacoub (2001) emphasised a spectrum on which an individual can exist relating to culture and religion, whereby cultural practice can be implemented so long as it does not conflict with Islam. There are distinctions between people in expression of faith, so to ascribe individuals as practicing or not practicing is discouraged in Islam. For instance, Yacoub (2001) explained that a Muslim can both wear clothes and eat foods that are considered as English customs and Asian customs as both have potential to infringe on or abide to the guidelines of Islam, despite the cultural origin. Nonetheless, this is commonly dismissed by Muslims and non-Muslims as it could be associated that being British means not being Muslim, which is incorrect (Hankir, Carrick & Zaman, 2015). Diversity is notable and honoured in Islam, where discrimination against race, age, sex, nationality is refuted as demonstrated in the Quran: *Oh Mankind, verily We have created you from a male*

and female and made you in to nations and tribes, that you may know each other and not that you may despise each other… (Surah Al-Hujuraat 49:13).

The diagram of findings (*refer to page 57)* demonstrates the often-challenging process that young Muslims go through when they are attempting to negotiate and navigate the multiple parts of their experiences. An example of this can be the way that perspectives of mental health are influenced by generational guilt and expectations in culture, which can create an emotional response in YM, leading them to engage in a process of connecting to themselves. The Islamic psychology paradigm mirrors this notion as it implicates how individuals struggle *(jihad)* against the prevailing effect of the *nafs* (self/psyche) when trying to align with their *fitrah* (innate disposition) (Al-Ghazali, 2015). An aspect of the struggle includes observing what the soul requires and engaging in self-reflection, which has been reported to occur in a part of the *nafs* know has *nafs al lawwama,* the conscious self (refer to full explanation in literature review page 14). This is where individuals reflect internally and can identify where the conflicts lie, to address them and so the *jihad* (struggle) is not only about combating against the *nafs* but rather responding productively to the identification of what is incongruent with the self (Rothman & Coyle, 2018). Thus, demonstrating that some of the above theory can relate to the Islamic models of mental health.

The sub-category *Perspectives of Mental Health* demonstrated that there are differences in the way MH is perceived in light of religious and cultural understandings. There is an acknowledgement of the medicalised view of MH that is held amongst YM; however, they endorse a more holistic understanding of MH difficulties. This also applies to the Islamic perspective of MH that considers the overarching patterns of emotions, behavioural displays, thoughts, values, and mental difficulties as part of a wider understanding of an individual's experience (Farooqi, 2006). It is a common belief amongst Muslims that being unwell can be positive occurrence that cleanses the body from sins, leading Muslims to be inactive in overcoming illnesses (Ali et al, 2009). This can impact help-seeking behaviours in Muslims due to the belief that it will cleanse the body (Rassool, 2000). Moreover, increased anxiety and depression amidst Muslims have been attributed to being unsafe, facing aggression and being misunderstood (Dunning, 2011). Additionally, marginalisation and discrimination contribute to

the MH difficulties of YM, leading to concerns around YM's susceptibility to identity distress (Ahmed, 2009).

The findings of the current study highlight the issue of language whereby participants' identified some terminology that insinuated MH difficulties. They used physical symptoms rather than emotional, which brings to light what could be missed in translation and/or understanding and conceptualisation of MH difficulties between languages. Therefore, there is still a requirement to address language barriers in being able to understand the experiences of others in the UK (Arafat, 2016). There is a recognition of culture and language in research that have a substantial influence in interactions between a service user in MH settings (Hale, 2011). This includes interpretation between languages which need a significant amount of proficiency to translate the meaning (Putsch, 1985; Tribe & Morrissey, 2004). Individuals who have English as their second language may struggle to communicate their emotions compared to their first language (Imberti, 2007). This may be due to difficulties in identifying words that signify the feeling when translating in a different language, as there may not be words that correspond to the meaning (Newmark, 2003).

There are many ways that culture and religion can impact the development of MH perceptions in YM people. The gender differences in this area are evident in the literature even though there are disparities depending on sociocultural, cognitive, biological, and behavioural reasons, alongside emotional processes (Lewis, Haviland-Jones & Barrett, 2010). This has been explained through changes regarding the function of emotions and the way they are communicated and utilised within different cultures (Fischer, Rodriquez & Manstead, 2004). That means that, depending on the culture and the historical nuances within them, men and women are often expected to adopt culturally approved gender roles, for example, child caretaker and financial provider (Brody, 1999).

This present research found that men are expected to conceal their emotions whereas women are more able to express them. Research has shown that females tend to be more emotionally expressive than males throughout many cultures (Timmers, Fischer & Manstead, 2003). However, findings indicate that stereotypes for expressing emotion are clearer than experiencing emotion (Planet et al., 2000) Emotional differences between the sexes are

displayed depending on the manifestation of schemas that are preserved – such as independence vs interdependence (Cross & Madson, 1997). The emotional processing that occurs in the interactions between the self and others, depends on the biological aspects (e.g., temperament) and the cultural responses, providing a feedback loop that reiterates the differences between genders and gender roles and stressing differences around collectivism versus individualism (Brody & Hall, 2008).

It is important to consider the generational impact on the development of YM MH perceptions. Ansari (2018) noted that religious affiliation spans across age, gender, situations, and immigrant settlement within UK. Due to this, it is expected that religious positionings would differ between generations. The central contrast between generations is that first generation British Muslims incline towards viewing religion through a cultural lens, whereas second and successive British Muslims attempt to differentiate between religion and culture, impacting intergenerational disputations (Akhtar, 2021). Interestingly, the principles that informs identity for first generation Muslims was cognisant of 'country of origin orientations', as outlined by Zubaida (2009, p.82). This means that individuals viewed themselves in relation to their ethnic communities, such as Indian or Pakistani. Consequently, it is understandable that religiosity involved culture was superior as Islam was part of the ethnic identity and was related to the social aspects as opposed to individual religious practice (Hamid, 2016). Contrastingly, young British Muslims outline the importance of distinguishing between religion and culture, which has stemmed from the difficulty in conforming to their parents culturally informed religious customs (Maliepaard & Lubbers, 2014) and are determined to establish a collective Islamic identity that binds the Muslim community through religion (Akhtar, 2021). This reflects the findings in this research where some YM have created a division between religion and culture to identify an Islamic identity that can incorporate all aspects of their identities.

Findings of the present study highlighted that some YM questioned where their value lay, often contingent on materialism. The participants' noted that expectations were placed on academic and career success, beauty, and skin colour, over who they are as personalities and characteristics. The Rogerian position holds that humans tend to aspire towards progress, improvement and independence which leads to achieving actualisation (Proctor, Port & Guernsey, 2017). Consequently, individuals appraise their experiences through the actualising

tendency to gauge their value which allows humans to have an intrinsic skill of assessing what is needed for them to engage in a satisfying life (Joseph & Linley, 2004). This process can be disrupted when social situations feature 'conditional positive regard', which is where a person feels they hold value in some areas but not in others, interrupting their ability to actualise, causing their outlook to be influenced by their 'condition of worth' (Joseph & Linley, 2004, p.2). Rogers (1959, p. 209) described a 'condition of worth' as being obtained when there is 'conditional regard' that others hold which has been adopted as one's own self-concept. This can influence how a person views themselves, as the conditions of worth have been engulfed by others, rather than being chosen by the person (Rogers, 1959). Subsequently, MH struggles and distress can materialise and be integrated into the individuals' identity and self-perception (Proctor, Tweed & Morris, 2016).

This research highlighted societal perspectives of MH which included it being a sign of 'weakness'. However, participants' in this study outline the resources they identified within religion that supported their well-being. Provided that religion and mental well-being have been seen to have positive correlations, there have been inclinations to explore the way that religious communities have a leverage on the way MH is viewed (Bushong, 2018). There are paramount considerations of MH in Islam, yet it is common that Muslims do not make use of MH services (Padela et al., 2012; Tanhan & Francisco, 2019). Some of the issues that contribute to the lack of utilising services involve cultural beliefs, limited knowledge around MH services, and the stigma that can influence the way Muslims view services (Tanhan & Strack, 2020). Whilst it has been found that Muslims are more receptive and have affirmative outlooks towards seeking help, there remains substantial social stigma (Ciftci et al., 2012), affecting their social status and risking the community considering them as weak (Cinnirella & Loewenthal, 1999). The YM's in this study expressed the hidden and secretive nature of MH treatment and that it is rarely supported or encouraged to seek the help required. This supports the literature around the stigma that impacts the help-seeking behaviours in YM.

All participants' found guidance, support, and aid in religion, through a variety of religious resources. For instance, some YM sought the support of stories of the Prophets that highlighted adversities and how they overcame them as guidance to how they should approach their difficulties. The discussion of well-being in the Qur'an differs to that in the secular

literature. The seeking of happiness in the material world such as wealth and seeking copious positive emotions, are reflected as deceptive ideas of well-being in Islam (Joshanloo & Weijers, 2019). Islam ascertains that living a good life is dependent on the ultimate purpose of people, to worship Allah. It has been identified that there is an objective and subjective side to wellbeing in Islam (Joshanloo, 2013). The way of life prescribed by the Quran provides Muslims with an understanding of methods of living that they can abide by. However, the Quran acknowledges individual psychological states and a 'good life' being in relation to the persons circumstance (Joshanloo & Weijers, 2019). Furthermore, Islam highlights a social accountability for every Muslim. For example, piety does not require a Muslim to be celibate, monastic, or isolated from society (Ünal, 2006), rather that would be considered unrealistic, whilst also not adhering to the social responsibilities of being present in the community (Joshanloo, 2017).

Islam provides numerous practices that are accessible as coping mechanisms to withstand stressors, adversities, anxiety, and other mental difficulties (Abdel-Khalek, 2011). Amidst them are, Wudu (ablution), Quranic recitation, Dua (Supplication), Dhikr (statements to remember God, seek forgiveness etc), and fasting during Ramadan and other days like Mondays and Thursdays (Abdel-Khalek, 2011). These notions are supported in this study by the YM who found benefit in religious practices such as prayer and Quranic verses. For example, YM found the prayer to be useful as an act of worship itself, whilst also finding the daily structure that regular prayer provides, as strength and stability for YM (Hasanović, 2017). Some of the YM in this research identified the physicality of prayer, whilst also acknowledging the melodious act of reciting Quran within prayer which has been found to be a non-pharmacological way of reducing levels of anxiety (Ghiasi & Keramat, 2018). It was noted by Husain (1998) that the physicality of prayer, including altering positions, has a calming result on the body, whilst the required attentiveness of the mind in prayer diverts the focus from noticing pain. The postural changes have been seen to be mirrored by exercises that are advised by current doctors for chronic lower back pain (Rosmarin & Koenig, 1998).

The need for connection and expression of explicit religious needs are complex, particularly because of dynamics including language, education, and adaption due to migration that influenced first-generation Muslim populations (Hussain, 2009). The second and successive

generations, who can be held between dual cultures, are also existing between ideologies. There is a need to preserve and maintain a Muslims' identity, which confronts and challenges the gaps present in services (Hussain, 2009). Whilst there are records for why MH services are underutilised by minority ethnic groups, there is a lack of statistics and records throughout services that represent religious groups. This is alongside there being a recognition that religiosity is a protective factor against psychological and physical difficulties (George, Ellison & Larson, 2002; Hackney & Sanders, 2003). The YM in this study demonstrated multiple dualities that they are required to navigate between cultures, religious understanding, MH perceptions and more. The concern and need for more religious and culturally sensitive services that understand nuances is paramount, as is the responsibility for all MH practitioners, regardless of their background to cultivate and improve their awareness (Stuart & Ward, 2018; Hussain 2009).

5.2.1 Religion and Therapy

All participants' in this research found religion to contain resources that they were able to use as coping mechanisms and supported their MH. Recently, attention to religion and spirituality has increased in CP. Despite there being past tensions between religion and psychotherapy (Ellis, 1980; Freud, 2012), endeavours have been made to resolve the friction as demonstrated with expanding information in literature that is directed towards increasing proficiency (Vieten et al., 2013) and awareness of religious paradigms (Barnett & Johnson, 2011). Considering the prevalence of religion, and the religiosity gap between therapists and the clients they work with (Delaney, Miller and Bisonó, 2007), it is important to continue improving skills in this area of clinical practice (Jafari, 2016). There are many clients for whom religion is a key part of their identity, the principles by which they live their life and their outlook on the world. The significance of religion has been shown through help-seeking behaviours, adherence to MH help (Chadda et al., 2001), and choice of therapeutic intervention (Stanley et al., 2011).

The participants' relationship with religion in this study has a strong link to providing peace, routine, alleviation of distress, answers and more. This, alongside understanding the theoretical models that observe the influence of religion on MH can provide potential ways in which religion can assist in vindicating the adverse impact of life stressors on MH (Koenig & Futterman, 1998; Parker et al., 2003) and/or assess whether religious or spiritual challenges

are contributing to help-seeking behaviours (Barnett & Johnson, 2011). The implications of religion/spirituality (R/S) in therapy were investigated using the multicultural population of South Africa, where a high number of people observe a religion. It was shown that R/S (both varying in their definitions) are foundations for coping in both the therapist and client, however their incorporation into the therapeutic relationship continues to be an uncomfortable mix (Elkonin, Brown & Naicker, 2014). Clients directed and instigated the focus of their sessions on R/S, but therapists found it difficult to engage, either because of limited experience or personal difficulties and referred clients to other therapists. Another theme that was established was that religion was not included in psychology training programmes, despite being seen as important for clients (Bjorck & Kim, 2009; Patel & Shikongo, 2006).

The issue of cultural competence surfaced when research exposed disproportionately higher inequalities in accessing and receiving quality MH care because of race and ethnicity (Sibrava et al., 2019). Multicultural competency was incorporated in training to provide practices that increased awareness of ethnic and cultural variances, increased fair access and provision of therapy, resulting in more appropriate help for marginalised communities (Dukes & Gaither, 2017). Nevertheless, much of multicultural competency training focuses on ethnicity and race (Shafranske, 2016). There is little focus on diversity specific to R/S within multicultural competency training. This includes self-awareness on the presence or lack of presence of R/S outlooks, the way this might impact therapeutic work, exploration of R/S in clinical contexts, the integration of R/S beliefs, context, and practices in the whole assessment and intervention (when required) and the potential for working alongside religious leaders if needed (Vieten & Lukoff, 2022).

The YM in this study noted that the religious practices that they engaged in such as supplication, prayer, recitation of Quran increased their sense of well-being and offered coping mechanisms in times of stress as a source of relaxation. This highlights the clinical relevance of religion for MH in YM. Individual religious practice has been shown to decrease suicidality and increase optimism and hope (Mohr, 2013), and engaging in religious practices such as prayer, religious texts, prayer, and meditation have had positive impact on MH (Yamada et al., 2019). Moreover, many psychologists consider R/S to be significant factors in diversity and demonstrate an interest in addressing R/S topics with clients (Shafranske & Cummings, 2013).

This brings to question the reasons for R/S being ineffectively attended to, in psychology training, research, and practice.

Reasons for this include, the scarcity of training, levels of religiosity and bias (Oxhanler et al., 2021). One study observed 543 clinical and CP trainees, who recognised the importance of religion and spirituality in the lives of clients, however a fourth of them did not have any training related to R/S (Saunders, Petrik & Miller, 2014). Other research found that out of 532 doctorate trainees and training leaders in accredited programmes, R/S were ranked as the least focussed on in diversity training (Schulte, Skinner & Claiborn, 2002). Additionally, much of the doctorate trainings depend on 'informal and unsystematic' methods of acquiring learning on R/S diversity (Vogel, McMinn, Peterson & Gathercoal, 2013; Vieten & Luckoff, 2022, p. 15; Vieten, 2016). Regarding religiosity, psychologists were found to be significantly less religious than those they work with (Shafranske & Cummings, 2013) comparative to other MH specialists (Oxhandler et al., 2019). Although being skilled in working with R/S issues does not require professionals to be religious or spiritual, it could be that its limited importance to psychologists could result in overlooking it as a significant part of multicultural competency (Vieten & Lukoff, 2022). Moreover, research has shown that some psychologists hold negative biases dependent on apparent religiosity. It was found that Christians were perceived to be less unwell than those who followed Mormonism, and even less than those associated with any sect of Islam (O'Connor & Vandenberg, 2005). Conclusively, the professionals differed in their assessments of clients based on their association with a particular religion.

The findings from this study have shown how religion and culture play a significant role in the lives of YM and the shaping of their MH perceptions. Hodge (2013) considered the need for habitually including religiosity into assessments to cultivate a wider understanding of clients regardless of whether it's the focal point of therapy, as it can offer essential contextual information (Sharfranske & Sperry, 2005, p.20). Additionally, Hodge (2013) promoted the use of 'biopsychosocial-spiritual assessments' for all clients to enhance the usefulness of treatment, suggesting a two-stage model of assessment (p. 223). The first stage involves an initial appraisal, establishing whether religion or spirituality is important to the client to see whether a further assessment of the problems is required. From this, a broader assessment can be included of the clients R/S background, implementing mapping tools to understand

their R/S applicable to life and relationships. Dein (2013) maintained that R/S is connected to many presentations and could be relevant to depression and anxiety as questions around purpose of life and/or lack of control over life. Moreover, difficulties surrounding health, grief, relationships, and existential problems, which challenge the way people view the world, may need consideration of R/S matters in therapy (Sperry, 2012; Pargament & Saunders, 2007).

The significance of R/S in the physical and psychological lives of individuals is well-reported. Research has explored whether R/S is efficient in psychotherapy, revealing encouraging results of R/S inclusive interventions for many disorders, such as depression, trauma, anxiety, post-traumatic-stress-disorder, schizophrenia, and health related illnesses (Ross, Kennedy & Macnab, 2015). Interestingly, in 1999, McCullough examined empirical evidence for 'religious-accommodative approaches' in depressed clients (p. 95), suggesting that straight after therapy was finished, religious approaches to therapy did not have greater results compared to standard therapeutic treatments. The findings also validate other reviews that have suggested equal effectiveness for 'religious-accommodative approaches' and the standard interventions in therapy (Worthington et al., 1996; Johnson, 1993; Matthews et al., 1998). In more recent research, there is not enough evidence to support R/S as being more or less beneficial, encouraging further research in this area (Agorastos et al., 2012; Aten & Worthington, 2009; Bonelli & Koenig, 2013; Masters, 2010; Koszycki et al., 2014; Ripley et al., 2014; Gartner & Jennings, 2013). Nonetheless, knowledge and understanding of the application of R/S difficulties can attend to improving skills and contributes to inclusive practices that therapists can offer their clients (Ross, Kennedy & MacNab, 2015).

The model presented in this research could be used to inform the processes in which YM conceptualise and make sense of the inclusion of cultural and religious dynamics within their MH perceptions. This covers aspects of coping, developments of MH perceptions and the way they are included into their outlook of life and the contributing factors that lead to the conceptualisation of their MH difficulties. The theory that was developed can provide one explanation of the process that individuals go through when trying to understand their perceptions within the frameworks they are navigating in (i.e., culture and religion). This is in conjunction with developing further understanding on the integration of culture and religion

and how it influences individuals, to have a wider contextualised understanding of the way culture and religion influence the lives of Muslims.

5.3 Implications for Counselling Psychology

Based on the findings of this research, there should be more training provided to enhance awareness and understanding for clinical practitioners that addresses cultural and religious nuances in interventions. The findings also highlight the need to distinguish between spirituality and religion to ensure due to the systemic nature of religion, that includes structures, practices, and regulations in which a religious person adheres to. This would be useful in utilising religious practices within therapy as methods of regulating an individual's mental and physical well-being. An example of this, could be in line with behavioural activation in Cognitive Behavioural Therapy (CBT) that requires clients to engage in behaviours to re-engage their emotionality, with the incorporation of the activities that are present within Islam that could be used to those who incline towards religion.

The current study offers original conceptualisation of the ways that religion and culture influence YM and their development of MH perceptions in the UK. This is the first study to conceptualise these aspects together in one research, providing valuable insight for the CP profession. Services can facilitate and accommodate for the needs of YM whilst incorporating the varied religious-cultural circumstances to increase the effectiveness of the psychotherapeutic approaches (Farooqi, 2006). This research hopes to contribute to the discussion around YM MH and the ways the development of their perceptions can inform the way therapy is practised.

The findings of this research can be useful in providing services for YM that acknowledges the complex processes that they hold and navigate in their every day, and the importance of these, sometimes conflicting, elements in their life. The research has noted that the number of YM who require MH services is still unknown. However, it has been observed that since Covid-19 pandemic, the needs of YM in the UK has risen exponentially (MYH, 2020). It has been reported many times that the lack of knowledge about Islam and the cultures that reside alongside those practicing Islam can impede on the service that is given (Anand & Cochrane, 2005; Callan &

Littlewood, 1998; Greenwood, Hussain, Burns, Raphael, 2000; Hussain & Cochrane, 2004; Rodrigues, 2011).

Findings of the current study have highlighted the resources in religion that YM benefit from and implement as part of their life, but also in aid of their wellbeing which can be useful in CP for constructing interventions to be inclusive of religious practices. Given that Islamic psychology has been around since the time Islam began, the attitude towards MH includes holistic methods, including prayer, nutritional elements, psychological, cognitive, and applied approaches are also provided. There is the potential for some professionals to view religion as just formalised theories that constrains the lives of individuals. This outlook can obstruct clients from conveying this part of themselves in the therapeutic alliance (e.g., Hussain & Cochrane, 2004), thus overlooking fundamental information. Therefore, perceptions of MH are not able to be comprehended in seclusion to religion and culture which can be instrumental in the treatment of MH in YM within MH services.

Additionally, from the findings of this study, there should be changes in policy so that training is provided to ensure sufficient levels of religious and cultural understanding. Through training and policy changes, there would be an impact on supervision. As this research shows, there can be enhanced comprehension of the unspoken, subtle rules of culture and religion and how levels of religiosity, schools of thought, cultural implementation, and the way YM are navigating numerous dualities can be brought to awareness in clinical practice. It is important to note the vagueness of terms to do with 'cultural differences' and 'cultural sensitivities' in MH services (Young, 1997, p. 368). It has been stated in research that some of the descriptions pertaining to this can provide shallow examples related to language and lexicons, disregarding the impact on a person's sense of self (Bhugra & Ayonrinde, 2016). By remaining focussed on the differences between cultures amongst minority groups can discount the influence of religion in individual lives, along with the impact of other processes (and other socio-economic issues) that effect a person's life.

Wider societal, western ideals can contradict and/or complicate some of the experiences of YM. Whilst it may be challenging to identify and cover all aspects of religion and culture, particularly as there are aspects that are specific to each client, there is a need for developing

understanding around MH perceptions in YM especially to address the barriers to service use and the need for well-defined models and theories that can provide a paradigm for researchers and practitioners (Agilkaya-Sahin, 2019; Tanhan & Francisco, 2019; Tanhan & Strack, 2020). This is even more so considering the recent Covid-19 pandemic, where religious and culturally sensitive research and services are required (Arslan & Yìldrim, 2021; Tanhan, 2020; Tanhan et al., 2020a, 2020b; Yildrim et al., 2021a).

Moreover, distinguishing between religion and culture could have essential consequences for treatment. By limiting the attention to these differences, it can result in pathologizing religious principles and behaviours, with professionals mislabelling damaging traditions of culture (e.g., forced marriages) as religious practices (Bukhari et al., 2019). This can lead to challenges within therapeutic practice by practitioners denoting that religious behaviour is constricting or emphasising that abandoning their religion will aid in recovery, ignoring the importance and freedom that can come with practicing Islam for Muslims. Subsequently, understanding how culture and religion are used by YM in the UK is important to increase awareness of postulations that may be held by professionals, and to contextualise MH difficulties.

5.4 Suggestions for Further Research

Whilst the findings demonstrate the importance of religion and culture in the lives of YM, further research could assist in multiple ways. Firstly, some consideration needs to be placed in developing frameworks that can inform and improve psychological interventions. The lack of distinct training methods and religion-informed models of working with clients is evident in current clinical contexts. Previous research has found that therapists are unclear and ambiguous about working with varying religions and are unsure about their own effectiveness in utilising certain interventions (Kellems, Hill, Crook-Lyon & Freitas, 2010).

Additionally, more attempts to increase the significance and perception of religion within CP programmes is important as religion can be underrated. More education on the value and role of religion in the lives of clients must be explored further, also in terms of clinical outcome. Whilst there have been some developments that sought to resolve the little attention that religion receives (Jafari, 2016), there is still high need to provide training for religion, equal to

other segments of diversity. As shown in the findings of the current study, religion plays an essential role in the lives of YM.

Lastly, there is limited statistical evidence available that showcases the extent of the MH difficulties being faced in the Muslim community. As this research has shown, there is stigma and judgement that can hinder the prospect of acquiring accurate results, however, more statistical evidence is better than none to understand the range of the phenomenon. Subsequently, more in-depth understanding needs to be acquired on understanding the needs of young Muslims MH. This study looked at the impact of religion and culture on the development of MH perceptions of YM, providing initial insights on the way that these integrate into their perceptions. More research is needed around help-seeking behaviours and YM use of services. This will aid in developing more culturally and religiously sensitive interventions within MH services.

5.5 Limitations of Research

The process of detecting and disclosing limitations of a study in conducting research is essential in contextualising the findings, observing possible errors produced from collecting data, to establish the significance of the research on other applicable areas (Vickers, 2016). Although reflexivity was undertaken throughout the research process to counter any potential biases, natural blind spots may still occur. By acknowledging the limitations, a discussion can be formed on the research area to inspire further research. Below, there is an exploration of the limitations of the present study.

5.5.1 Limitations of Present Study

The current study recruited participants' through social media platforms such as Instagram and WhatsApp groups (i.e., various university Islamic societies, Islamic groups) as well as word of mouth. It is possible that those who were interested in the topic were more likely to take part, thus ensuing selection bias (Robinson, 2014). As participants' volunteered to take part in this research, this can influence the results as they may have been positive towards the study and the topic. Further research on the theory the present study generated could address this limitation by continuing to investigate the perspectives of YM who may have alternative views towards religion and culture.

Additionally, it is important to note that due to the researcher presenting in religious attire, there may have been an influence on participants' responses. Participants' might have made assumptions on the researcher's religiosity (very religious or not too religious). Had the interviews been conducted by someone from a different religious background or no religious affiliation alternative findings could have been provided. This is partially because researchers that have outsider status may be more curious to certain aspects of participants' experiences or notice aspects that could be 'normal' to the current researcher, such as shared religious language between researchers. Nevertheless, participants' noted that they felt more comfortable talking to someone who shared the same religion as it made them feel comfortable and not judged.

This study was conducted online due to the global Covid-19 pandemic which limited in-person interactions. The benefits to this were wider outreach where participant who took part in this research were from numerous areas around the UK. The downside was that participants' did not always have exclusively private spaces, resulting in some interruptions, be it someone walking in the room or connectivity and technological issues. It could be argued that this disrupts the depth in which participants' could disclose information, whilst also impacting the flow of conversation, and losing vital pieces of information. However, any disruptions were managed by repeating of questions and ensuring that the conversation was paused once privacy was compromised.

Finally, there are limitations to qualitative research. Some argue that qualitative research lacks credibility as it questions the usefulness of replicating a study if it produces different results (Borman et al. 2007). This is a limitation of analysis as the results represent the understanding and interpretation of the researcher, but it is acknowledged that a different researcher might have come up with alternative categories (Myers, 2019). Qualitative research tends to collect small sample sizes which limits the generalisability of the research to the wider population (Harry & Lipsky, 2014). Nonetheless, this issue is less spoken about in qualitative research as the aim of qualitative research is to enhance and understand subjective human experiences (Polit & Beck, 2010, p. 1451). It has been questioned by Wegner (2009) to implore the

possibility of results from qualitative research being generalisable to a bigger population. Therefore, it is important for the researcher to consider the transferability of findings.

5.6 Reflexivity

There are many reflections that are flitting through my brain. There is a huge bout of contemplation as I am starting to approach the end of the thesis. This marks the end of writing the doctoral thesis, however, it also officiates the end of the CP doctorate. I often think about the start of formulating ideas for this thesis and knowing that general area that I wanted to research, but having no idea how I would get there, what it would be or what it would look like. I ebbed and flowed in remembering, validating, and comprehending the importance of this research, often feeling the need to keep revisiting its purpose. This was until I conducted the interviews. Just before this happened, there was conversation happening that involved religion in my own professional doctorate course, which made me question the relevance of religion in wider society and made me question the dismissal of religion, including in training. That experience was an incredible learning curve. It was hard to understand the level in which religion felt alienated from talks of diversity, and I noticed its scarcity in conversation, unless it was criticised. However, I knew that it wasn't my experience of religion, nor was it the experience of those around me, or what I knew of religious communities. In some ways, it felt like a lifting of the veil (no pun intended). By starting to conduct the interviews and be in a privileged position to listen to the participants' experiences, I was able to see more clearly. The purpose was to give rise to these voices, the ones that are chronically unheard, unseen, and unprovided for. I wanted to give them a voice, and a place.

The doctoral journey has been a challenge, but one that has deepened my sense of self. Throughout this process, I have come to realise that in some ways, growth for me has been in the 'unlearning', the removal of that which I gained, the reprocessing and restructuring. I noticed primarily towards the last few weeks, since I have had more time to write consecutively, that even a year ago, I was thinking I am unable to write, my written abilities are poor, and I can't string a sentence together in a day. I am now in a position where when I had written a page or two in one sitting, to me is unfathomable. Albeit that is a small example of the changes, it reflects for me the smaller alterations that need to happen to have an overall change. The hope with this doctorate thesis is for there to be an understanding of the way

religion is compatible with MH interventions to contribute to training programmes and provide at least one perspective of the way YM navigate complexities within their life. I hope that this research can remove the constrictive and limiting ideas around religion and begin to see the ways in which religion can be used and implemented into MH services at least for those who want it. As this research has shown, religion is an essential feature of people's lives and the way they operate. To implement it in a new model or incorporate it in therapeutic models that already exist can be extremely valuable.

I have already found ways in which this research has enriched and added value to my own life and perspective. More recently, there have been conversations in my workplaces around bettering inclusion, but also the ways in which religion is still misunderstood and its incorporation into practice. In some ways, embarking on this process of completing my thesis, I have been able to observe the implications of the research and consolidate my own learning in trying to identify the gaps in practice. The journey to completing this thesis has been a difficult one full of the highs of conviction and self-believe and the pitfall of self-doubt and criticism. I remember thinking at the start of the doctorate that I couldn't imagine reaching the completion of the thesis. Lo and behold, I am now looking back on the ways that this research has empowered my learning, challenged my beliefs and perspectives, and allowed me to adopt new ways of observing religion and MH – encouraging thought on how to bring it in to practice.

There are many limitations to this research, and I am aware of the biases and assumptions that are part of this process, along with potential for some areas to be overlooked, impacting the overall emergent themes and direction of this research. This leaves a lot of room for further research to be conducted as this area is limitless. I feel like there is still an abundance left to learn, and this has been a significant part of my life as who I came in as and who I am leaving as are different. I am looking forward to continuing learning and gaining awareness of theories, and the expansion of this field. I feel grateful to have had this experience as it has touched lots of areas of my life whilst inspiring the next stages of my developmental process.

5.7 Chapter Summary

In this chapter, the findings were discussed in relation to the relevant literature, and in relation to the research question and sub-questions. This included the cultural and religious impact on

the development of MH perceptions, formulation of well-being around culture and religion and religious values, identities, and behaviours on MH perceptions. This chapter also explored the limitations of this research, qualitative research, and GT. The implications of clinical practice, CP and further research was also included in this section. This was concluded with a reflection on the research process as the study reaches its finality.

CHAPTER 6: CONCLUSION

6.1 Overview of the study

The research's endeavour to obtain an understanding of the impact of religion and culture on the development of YM MH perceptions was conducted using the constructivist GT. The purpose of this was necessary due to the limited understanding of how YM developed their MH perceptions, in the context culture and religion and the complexities within, and how this materialises. The findings of this study showcase the interaction between numerous complex dualities that YM navigate to develop their understanding of MH. The YM highlighted the importance of religion within their lives and found resources within religion to help cope and make sense of MH difficulties.

The main concept of ***Navigating Complex Multiplicities*** ascertains the way in which YM maintain and develop their identity, whilst adhering to social pressures that exist, and the ways that they consolidate these elements to fit their sense of self. The findings demonstrate a cyclical nature that a young Muslim experiences which includes ***expectations in culture, generational guilt and perspectives of Mental Health*** and the way that they begin to detach from the cycle because of strong ***affect,*** leading them to embark on their ***individual discovery***, which leads them to identify *resources in religion* and to ultimately negotiate these elements to ***Connect to their Self***. This research has identified that a YM perception of MH is impacted by layers of dualities which produces a complexity to the extent of the expectation placed on them. The experience of YM is not commonly recognised or comprehended and a lot more research could be done in this area. Thus, the findings of this research provide empirical insight into the processes that YM go through to construct their perceptions of MH, providing insight into their experience.

6.2 Chapter Summary

This chapter concludes the completion of this research study.

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JOURNAL ARTICLE

Abstract

Understanding the impact of religion and culture on Mental Health (MH) perceptions of YM (YM) is important because there is a lack of support and access for YM in MH services. ***Literature:*** The Muslim Youth Helpline (2020) demonstrates a 313% rise in Muslim MH, especially considering Covid-19. Studies that have looked specifically at MH in Muslims are limited, however the little that are available suggest that Muslim residents in Western countries did not often use the services provided. ***Methodology:*** qualitative research was implemented for this research, with GT being used to guide data collection and analysis. Semi-structured interviews were conducted with 10 YM and their perceptions of MH through the lens of religion and culture. ***Results:*** that the analysis of data led to one main category: *Navigating Complex Multiplicities* with seven subcategories: *Expectations in Culture, Generational Guilt, Perspectives of MH, Affect, Individual Discovery, Resources in Religion and Connection to Self.* The GT that derived from the analysis of the accounts demonstrates the interaction and process that YM go through which develop their MH perceptions. ***Conclusion:*** This research has identified that YM' perceptions of MH is impacted by layers of dualities which produces a complexity to the extent of the expectations placed on them. Thus, the findings of this research provide empirical insight into the processes that YM go through to construct their meaning of MH, providing insight into their experience.

Literature Review

Mental Health Perceptions

The World Health Organisation (WHO, 2017) views MH disorders to be considered a part of an amalgamation of abnormal emotions, behaviours, thoughts, and interpersonal relationships. It has also been reported that more than 300 million people (4.4%) of the world's population suffer from depression, leading to fatalities such as suicide and ischemic heart disease (Whiteford et al., 2013).

Despite the improvement to MH provisions, there are still a significant amount of people who either don't use the services or leave their treatment prematurely in the UK (Ciftci, Jones & Corrigan, 2013; NICE., 2019). One obstacle that mainstream psychology encounters is modifying therapeutic interventions to meet the needs of multicultural societies due to its historical efforts to detach from religion and philosophy (Haque & Kamil, 2012). However, it may be useful to observe the ways other cultures approach psychological awareness to be able to incorporate them in the West (Gibson, 2016).

Refugees and asylum seekers are often marginalised and vulnerable in our society, particularly with regards to accessing MH services in the UK (Burnett & Peel, 2001). Due to socio-economic deprivation and resettlement, there are many acculturation stresses that can impact MH whilst also requiring the development of cultural competency to provide for their needs (Oppedal, Keles, Cheah and Røysamb, 2020). Refugees consist of various nationalities, ethnicities, cultures, ages and therefore would require different approaches to meet their needs (Bhugra & Bahl, 1999).

Islamic Perspectives on Mental Health

Islam is regarded as a 'complete code of life' by those who adhere to the religion (Awaad et al., 2019). There are numerous ideas that contribute to the cause of mental illnesses in the Islamic context, including psychological, environmental, spiritual, supernatural, and biological influences (Ahmed & Amer, 2013). It may be that some mental illnesses have a biological element or could be intensified by environment and circumstances (e.g., poverty).

The Qur'an refers to supernatural beings that exist, and mental illnesses are often attributed towards these forces (Warden, 2013). These can be in the form of *wass wass* (whispers), *Sihr* (black magic), *Al- 'Ayn and Hasad* (evil eye and envy) and *Jinn.* Thus, psychiatric issues such as delusions can often be explained through the existence of *jinn* (spirits) which is treated through the extraction method called *Ruqyah* – Islamic exorcism (El-Islam, 2008). As a result of these supernatural forces, Muslims remain aware of the effects that these may have on people (Warden, 2013).

Many Muslims in counselling may assign some of their difficulties to supernatural influences, despite evidence to suggest other factors; for instance, marital issues, sicknesses, and other difficulties (Ahmed & Amer, 2013). A study looking at attitudes of Pakistani families on MH found that all their participants' would not consider marrying someone with a MH issue, half would interact with them, and a quarter would think of a close relationship (Ciftci, Jones & Corrigan, 2013).

Cultural Perspectives on Mental Health

In this research, culture refers to rituals, traditions and habits of a people that differs from place to place (Cambridge Dictionary, 2022). When discussing the study of culture, it is often found that religion and ethnicity are closely interwoven (Beyers, 2017). Development of identity is governed by multiple factors, so cultural identity is in a constant state of change (Vroom, 1996). Change can be driven through developing identity through belonging to a group and instilling a sense of order, certainty and meaning (Vroom, 1996) as well as transgenerational factors that begin in childhood with behaviours, beliefs and practices that are encouraged in the child (Ho, 2019). Individuals as a result are separated from traditional religious beliefs to adopt 'cultural-religious' identities that do not always comprise of religious material (Beyers, 2017). Cultural perspectives also influence their perception, help-seeking behaviours, attitudes, and behaviour regarding MH (Palmer, 2006).

The cultural perspective is essential when exploring perceptions around MH, as the interpretation differs between cultures (Choudhry, Mani, Ming & Khan, 2016), in turn influencing whether individuals chose to seek support (Dow, 2011). For instance, it was seen

that upon receiving a diagnosis, individuals no longer contacted services despite a therapeutic need (Tehrani, Krussel & Borg, 1996). This was due to several factors such as attitudes towards treatment, 'subjective norm' which relates to a persons internalised social pressure to engage with a behaviour, family's willingness to assist the relative and the long-standing effects of stigma that is attached to a mental illness (Corrigan & Wassel, 2008).

Young People and Mental Health in the UK

MH is increasingly becoming an issue for YP with several measures demonstrating a decline in well-being. It was found that women between the ages of 20 to 24 in the UK reported low life satisfaction and happiness and high anxiety compared to five years prior (Rees, 2020). It was shown that anxiety and depression was recorded at 31% in those aged 16 to 24 in the UK: which is an increase from the year before which was recorded as 26%. There has been a rise of YP aged 16-24 who are faced with financial difficulties and feelings of disconnection from their communities (Gromada, Rees & Chzhen, 2020).

The beginnings of MH issues are most prevalent in adolescence and early adulthood (Kessler et al., 2005) whereas the onset of physical illness tends to be later in life. Early adulthood is a time that is significant for various reasons such as it being a transitional period from adolescence to adulthood, gaining responsibility and independence (Hoffman, 2002). YP's MH is a great concern, with most diagnosable MH issues occurring between the ages of 12-25 in the UK (Royal College of Psychiatrists, 2010). Although there is an acknowledgement in policies (NHS England, 2016), there is still a low number of YP utilising primary MH services in the UK (Bunglawala, Meha & Tunariu, 2021; Issakidis & Andrews, 2006). Literature conclusions on causes include self-reliance (Salaheddin & Mason, 2016), negative attitudes and experiences towards obtaining services (Rickwood, Deane & Wilson, 2007) and stigma (Schnyder, Panczak, Groth & Shultze-Lutter, 2017).

Young Muslims and MH Perceptions in the UK

Although studies that have looked specifically at MH in Muslims are limited (Abu-Raiya & Pargament, 2011), the little that are available suggest that Muslims who reside in the West did not often use the services provided (Weatherhead & Daiches, 2010). It is reported by Walpole and colleagues (2013) that British Muslims cannot access culturally or religiously sensitive

health professionals and so are unlikely to seek MH help in primary care. This also means that they are expected to end up in the criminal justice system in a calamity; have limited awareness of ways to gain MH help, whilst maintaining a different outlook on MH; and they are more uncommon to be referred to therapy whilst more likely to be medicated (Bignall et all., 2019).

Geaves (2010) argues that the first-generation Muslim used religion as an identity marker that allowed them to build a community whilst playing a part in 'micro-politics'. The second-generation would then become more involved in the British culture and society which created a tautness, particularly with religious scripture in the midst that provided written and evidence-based reference that allowed the bypass of culture. This meant that an observance of the main foundations of Islam through the Qur'an and Hadith are referred to as a point of reference over culturally influenced understandings (Geaves, 2010). This allowed the younger Muslims to have the option to implement the Qur'anic text that allowed the separation from cultural expectation, whilst other YM were able to integrate the religious, ethnic, and secular standards in a way that suited them better (Geaves, 2010). The interaction of each of these elements may have a fundamental effect on the MH perceptions developed in young Muslim people.

Aims

The aim of this research is to explore the specific characteristics of the processes with which Religion and Culture influence the development of MH perceptions in young Muslim people in the UK. To gain an understanding of the processes of the participants', the research question that was used is: ***What are the cultural and religious influences that impact the development of MH perceptions in Muslim young people?***

The sub-questions that interact with the research questions are as follow:

1. What are the ways that culture and religion impact the development of mental health perceptions in young Muslim people?
2. What are the ways in which young Muslim people formulate their well-being around culture and religion?
3. How does religious identity, values and behaviour affect beliefs regarding mental health perceptions?

Method

The method that was used for this research question was a qualitative design as it was deemed the most suitable for gaining insight into participant perspectives (Silverman, 2020). For this research, qualitative methodology was implemented to answer the research question through implementing semi-structured interviews with young Muslim people's, exploring their perceptions. GT was used to analyse the data (Charmaz, 2014).

Sample

For this research, young adults between the ages of 18-25 were recruited to take part. The inclusion criteria included Muslim YP, from any cultural background, between the ages of 18-25. The exclusion criteria included anyone under the age of 18 or above the age of 25, identifies as non-Muslim and people with severe psychological distress that puts them at a higher risk of distress during interviewing. An initial sample size of 10 individual interviews, recommended by Charmaz (2014), was collected for this research to identify patterns in the data to provide a range that allows you to stop when saturation starts happening depending on the accessibility and availability during the collection of data (Gough & Conner, 2006).

Data Collection

The data was gathered using semi-structured interviews to investigate the process of development of MH perceptions as affected by culture and religion. The interview was conducted after the initial sampling of participants' who fit the inclusion criteria to collate an exploration of first-hand experiences using open-ended questions that led to obtaining detailed responses, meanings and experiences related to the development of MH perceptions of Muslim YP. The interview questions were constructed by developing open-ended questions to explore the participants' experiences, concerns and thought processes on MH.

Data Analysis Process

Strauss and Corbin (1998) propose three stages of analysis in GT which includes: open coding, axial coding, and selective coding. 'Open coding' is the first part of the data analysis where the transcription was visited line by line by the researcher in attempts to pinpoint codes to classify, name, categorise words or phrases that highlight what is occurring or inferred in the data.

Following this, 'axial coding' was the process of determining the relationship between ideas and where new thoughts or categories arose. These concepts are abstract and 'higher in level' than what they signify (Corbin & Strauss, 1990, p. 7). Axial coding sought to ensure that the categories and sub-categories closely symbolise what participants' expressed in interviews.

Finally, 'selective coding' is the stage where there is an assimilation of the categories found in axial coding, proposing an initial theory. It is the stage of choosing core categories. This stage recognises the reconstruction of the participants' stories by the researcher with the aim of encourage the voice of participants', despite the researchers own inescapable interpretations (Strauss & Corbin, 1994, p. 281) with the presumption that a theory will surface (Corbin & Strauss, 2008).

Risk & Ethical Issues

Informed consent signifies gaining the permission of an individual before continuing with the research. It requires informing the participant of what is expected, risks and the nature of the research which allows the participant autonomy to agree or disagree in taking part (Lo, 2009). The participants' were provided with a follow-up check-in and resources that can be contacted post-interviews for additional support. The participants' were also fully debriefed before, during and after the interview process to give them as much support as I can. Due to the current global conditions of Covid-19, it was important to consider how the interview process might be impacted, thus, modified the methods of interviewing. The use of online programmes such as Microsoft Teams were used to conduct interviews.

Results

Diagram of Findings

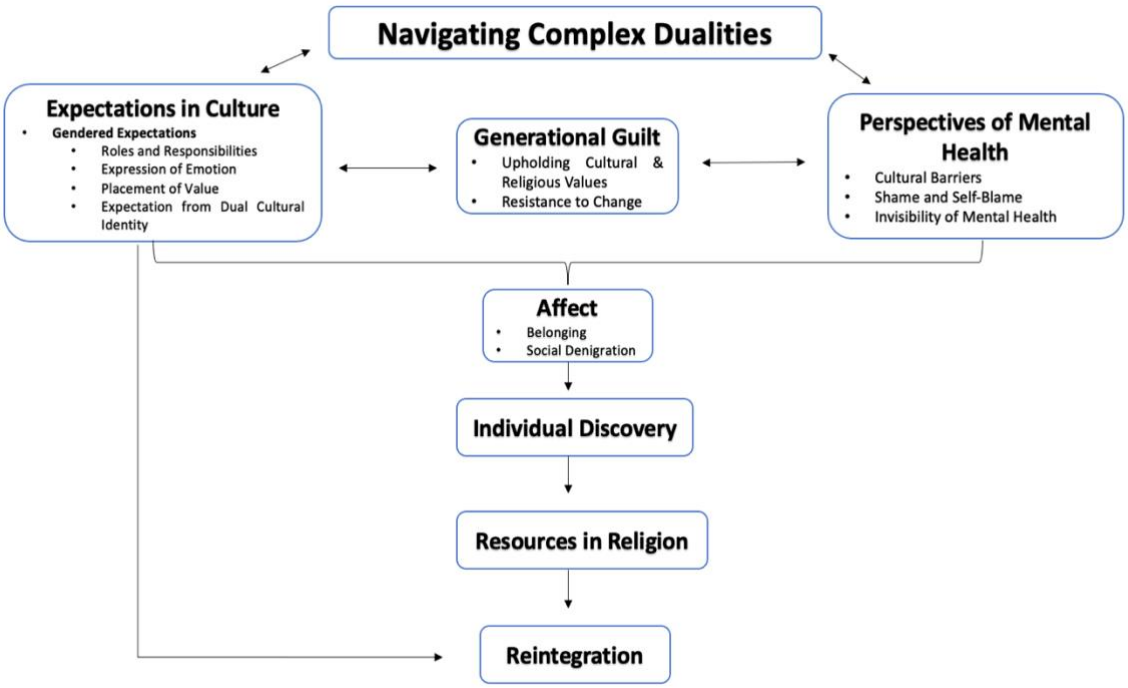

Figure 4: Concepts that emerged through Selective Coding.

Navigating Complex Multiplicities informs this process that YM undergo to balance and do justice to all these different aspects of their life. The complexity of these dualities stems from their often-dichotomous standpoints resulting in a split in various aspects of their experience. The split leads to varying Perspectives of MH, Generational Guilt, and Expectations in Culture. A split occurs when a person is left holding dual perspectives that conflict with one another. For example, participants' experienced duality in a sense of self, including their religious, cultural, and British identities and their respective expectations, whilst trying to align with their sense of self. Consequently, their sense of belonging to certain communities is impacted.

These three categories are cyclical in nature as they are interlinked. Expectations in Culture can often be a cause of Generational Guilt and therefore influences Perspectives of MH. Equally, Perspectives of MH can alter Expectations in Culture which can also induce Generational Guilt. This process of Navigating Complex Multiplicities produces an emotional response, referred to as Affect, that begins to develop over time causing an influence on behaviour. Consequently, and perhaps simultaneously, individuals initiate an Individual Discovery process which is a personal journey that questions the legitimacy of religion, culture

and start to learn to distinguish between them. This occurs through seeking knowledge about religion, questioning religious perspectives of MH, and discovering that there can be discrepancies in interpretation and implementation of religious concepts within cultural contexts. Through this understanding, YM explore what is important to them, increasing their knowledge of religion to seek answers for the challenges they are facing.

Through this, they identify Resources in Religion that provide support, understanding, and methods that can be included as part of their recovery, healing, and maintenance of their MH. As part of their Individual Discovery, YM may struggle with balancing potential incompatibilities between culture and religion. YP may want to continue embracing elements of their culture and go through a negotiation process of prioritising parts of culture that align with their religious beliefs and sense of identity. This negotiation is made in accordance with their experience, where a young person identifies parts of culture that they value and work to incorporate them into their life within the boundaries of religion. This is dependent on the context, level of religiosity and importance of culture and the way these dualities were navigated. This is where YP discovers their sense of self, perspectives, beliefs, and identity in Connection to Self.

Above highlights an overview of the process that YM go through in conceptualising their perceptions of MH. This will be explored in detail below through the explanations of each category.

Discussion

This study found that YM sense of belonging is affected by their dual cultural identities. On one hand, YM found a sense of community in their socio-cultural-religious identities and the practices within them. Alternatively, YM found that it was difficult fitting into one community without consequently feeling like they don't belong which can impact their MH. Research shows that religious beliefs of Muslims influence the MH of individuals, communities and families and are an important part of their identity (Nasser-McMillan & Hakin-Larson, 2003). Research conducted on YP from many minority groups, such as religious, cultural, and racial,

propose that discovering a community that allows them to be a member of the group and getting support from the group, allows this group of YP to develop a sense of belonging (Hannon et al., 2016). It is also put forward that a sense of belonging to a community safeguards individuals from mental distress that stems from minority-related challenges (Grossman & Liang, 2008). Therefore, experiences that encourage promising social interactions can communicate a sense of recognition and belonging that can guard YM from the negative impact of discrimination allowing them to regulate in accordance with their environment (Totonchi et al., 2022).

All participants' in this research found religion to contain resources that they were able to use as coping mechanisms and found supported their MH. Recently, attention to religion and spirituality has increased in CP. Despite there being past tensions between religion and psychotherapy (Ellis, 1980; Freud, 2012), endeavours have been made to resolve the friction as demonstrated within expanding information in literature that is directed towards increasing proficiency (Vieten et al., 2013) and awareness of religious range (Barnett & Johnson, 2011). As religious belief is present on a global level, as well as the seeming gap in faith between therapists and clients they work with (Delaney, Miller & Bisonó, 2007), it is reasonable that continuing to improve skills in this area of clinical practice is important for the MH field (Jafari, 2016). There are many clients for whom religion is a key part of their identity, the principles of which they live their life and their outlook on the world. The significance of religious faith has been shown through help-seeking behaviours, adherence to MH help (Chadda et al., 2001) and choice of therapeutic intervention (Stanley et al., 2011).

Some of the reasons for this includes the scarcity of training, levels of religiosity and bias (Oxhanler et al., 2021). One research that observed 543 clinical and CP trainees, who recognised the importance of religion and spirituality in the lives of clients, however a fourth of them did not have any training related to R/S (Saunders, Petrik & Miller, 2014). Another research found that out of 532 doctorate trainees, training leaders in accredited programmes, religion and spirituality were ranked as the least focussed on in diversity training (Schulte, Skinner & Claiborn, 2002). Additionally, much of the doctorate trainings depend on 'informal and unsystematic' methods of acquiring learning on R/S diversity (Vogel, McMinn, Peterson & Gathercoal, 2013; Vieten & Luckoff, 2022, p. 15; Vieten, 2016). Regarding religiosity in

psychologists, it was found that psychologists are significantly less religious than those they work with a (Shafranske & Cummings, 2013) and comparative to other MH specialists (Oxhandler et al., 2019). Thus, although to be skilled in working with R/S issues doesn't require professionals to be religious or spiritual, it could be that its limited importance to psychologists could result in overlooking it as a significant part of multicultural competency (Vieten & Lukoff, 2022).

The model that was presented in this research could be used to inform the processes in which YM conceptualise and make sense of the inclusion of cultural and religious dynamics within their MH perceptions. This covers aspects of coping, developments of MH perceptions and the way they are included into their outlook of life and the contributing factors that lead to the conceptualisation of their MH difficulties. The theory that was developed can provide one explanation of the process that individuals go through when trying to understand their perceptions within the frameworks that they are navigating in (i.e., culture and religion). This in conjunction with developing further understanding on the integration of culture and religion and how it influences individuals to have a wider contextualised understanding of the way culture and religion influence the lives of Muslims.

Limitations

This study recruited participants' through social media platforms such as Instagram and WhatsApp groups (i.e., various university Islamic societies, Islamic groups) as well as word of mouth. It is possible that those who were interested in the topic were more likely to volunteer to take part, thus ensuing selection bias (Robinson, 2014). As participants' volunteered to take part in this research, this can influence the results as participants' may have been more positive towards the study, such as their perspective of MH, religion, and culture respectively, than is representative. However, as the scope and reach of participants' is unknown due to being shared on social media, and reposted by others, it is uncertain as to whether this is accurate.

APPENDIX

Appendix A

Ethics Application Form

xxSection 1: Applicant Details	
First Name	Iman
Last Name	Idjer
Faculty	HAS
Department	Health and Social Sciences/ Psychology
Co-researcher Names (internal and external) Please include names, institutions and roles. If there are no co-researchers, please state N/A.	N/A
Is this application for a staff or a student?	Student
Student Course details	Postgraduate Research
Name of Director of Studies / Supervisor	Eva Fragkiadaki
Comments from Director of Studies / Supervisor For student applications, supervisors should ensure that all of the following are satisfied before the study begins: The topic merits further research; The student has the skills to carry out the research; The participant information sheet is appropriate; and procedures for recruitment of research participants' and obtained informed consent are appropriate. The supervisor must add comments here. Failure to do so will result in the application being returned	
Click or tap here to enter text.	

Section 2: Project	
Section 2:1 Project details	
Full Project Title	
Cultural and religious influences in developing mental health perceptions in Muslim young people: A grounded theory research.	
Project Dates These are the dates for the overall project, which may be different to the dates of the field work and/or empirical work involving human participants'.	
Project Start Date	16/09/2019
Project End Date	21/06/2022
Dates for work requiring ethical approval You must allow at least 6 weeks for an initial decision, plus additional time for any changes to be made.	
Start date for work requiring ethical approval	10/10/2020
End date for work requiring ethical approval	31/08/2022
How is the project funded? (e.g. externally, internally, self-funded, not funded – including scholarly activity) Please provide details.	

Self-Funded

Is external ethics approval needed for this research?	No

If Yes please provide the following:

For NHS Research please provide a copy of the letter from the HRA granting full approval for your project together with a copy of your IRAS form and supporting documentation, including reference numbers.

Where review has taken place elsewhere (e.g. via another university or institution), please provide a copy of your ethics application, supporting documentation and evidence of approval by the appropriate ethics committee.

Click or tap here to enter text.

Section 2:2 Project summary

Please provide a concise summary of the project, including its aims, objectives and background. (maximum 400 words)
Please describe in non-technical language what your research is about. Your summary should provide the committee with sufficient detail to understand the nature of the project, its rationale and ethical context.

What are the research questions the project aims to answer? (maximum 200 words)

This research is concerned with the interaction of Cultural and Religious influences in developing Mental Health Perceptions in Muslim Young People.

The cultural perspective is essential when exploring perception around mental health, as the interpretation differs between cultures (Choudhry, Mani, Ming & Khan, 2016), in turn influencing whether or not individuals chose to seek support (Dow, 2011). For instance, Southeast Asian populations observed that supernatural occurrences are liable for mental health issues, resulting from rejecting that existence of spirits and divinities (Khan, Hassali, Tahir & Khan, 2011). Alternatively, Pacific Islanders viewed mental health conditions to materialise from problems in families (Douglas & Fujimoto, 1995).

Studies that have looked specifically at mental health in Muslims are limited (Abu-Raiya & Pargament, 2011), however the little that are available suggest that Muslim residents in Western countries did not often use the services provided (Weatherhead & Daiches, 2010). The use of Islamic practice such as prayer, recitation of the Quran and fasting, as coping mechanisms for adversities in life has been recognised as the main reason why mental health services are not sought (Loewenthal & Cinnirella, 1999), whilst other reasons include mental health stigma and the stereotypes that exist in society (Ciftci, Jones & Corrigan, 2013). This suggests that there is a gap in mainstream psychology that falls short of meeting the mental health needs of Muslims.

There is very little research that explores Muslim young people in non-Muslim countries perceptions of mental health preventions or treatments (Harroun et al., 2011). One research investigated psychosocial adaptation and the internalisation of issues in Young Muslims in Norway (Oppedal & Røysamb, 2007). There were multiple findings, namely that different genders and ethnicities within the bounds of Islam showed differences in psychosocial risk and internalisation of issues. For example, girls were more likely to internalise family issues, and gender role expectations (Kessler & McLeod, 1984), whereas Turkish and Somali boys were concerned with developing an identity and competency in the Norwegian culture (Kessler & McLeod, 1984) .

There is a gap in the literature for Young Muslim individuals living in the United Kingdom, particularly around their perceptions and conceptualisation of mental health issues. Although there are numerous ways in which mental health may be perceived by Muslims,

young people's experiences may differ by having obtained the cultural and religious factors from their families, whilst adapting and maintaining the Western ideologies (Haroun et al., 2011). Thus, there is room for observing young people's mental health perceptions in the Islamic culture, using qualitative research.

Aims and Objectives

The evidence presented above highlights a paucity in qualitative literature which explores mental health perceptions in young people exposed to religion and culture, particularly the Islamic faith, given its immersive status. Research is limited when observing young Muslim individuals and their mental health (Altalib et al., 2019), especially as all existing research has largely used quantitative methods to collect their data. The present project aims to contribute to and build upon existing research and theory on how culture and religion impacts the development of young Muslim people's mental health perception in the UK by implementing a qualitative methodology and in particular Grounded Theory. This allows the researcher to explore the processes of development of young Muslims' mental health perception and the way in which culture and religion have an influence. The findings of the study will shed light on the significant factors in the field of mental health literacy for this population, aiming to inform mental health services and interventions.

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Please describe the research methodology for the project. (maximum 250 words)

The qualitative research design that will be used in this research is Grounded Theory (Charmaz, 2014). The data will be gathered using semi-structured interviews to investigate Muslim participants' mental health perceptions. Interviews will be suited to this study as it will focus on the impact of culture and the process of development of mental health perceptions for young people to observe the factors that are most important to them (Braun & Clarke, 2013). Due to the nature of the interviews, there are a multitude of factors to consider, such as interviewing strangers, power in the interview, societal positions and distress (Braun & Clarke, 2013). Therefore, a level of rapport would need to be developed with the participants' to be able to produce rich data whilst developing and upholding respect between the researcher and the participants' (Guillemin & Heggen, 2009). This can help to encourage effective communication, leading to gathering meaningful data (Youell & Youell, 2011). The use of reflexivity will be implemented in order to bracket any subjectivity that may arise, with constant rigorous reflection.

Using Grounded Theory, the initial sampling will involve participants' who fit the inclusion criteria; Muslims young people, from any cultural background between the age of 18-25. The exclusion criteria will be anyone who has struggled with mental health issues that renders them unable to consent. Therefore, beginning with creating criteria and observing how the data could be accessed (Charmaz, 2014). Grounded Theory will allow room for gathering rich data as it allows flexibility by providing room for a follow up on what is happening after coding and categorising of the data has happened (Charmaz, 2014). The interview will then be conducted after initial sampling to collate an exploration of first hand experiences using open-ended questions that can lead to obtaining detailed responses, meanings and experiences. Grounded theory also allows room for a follow up of unanticipated areas of enquiry if needed (Charmaz, 2014). Following this, initial coding will take place, whereby the data will be categorised with short names that summarises and accounts each piece of data to demonstrate how the data has been selected, separated and sorted which will lead to the analytic accounting of them. Alongside this, maintaining a memo-chart will help provide a detailed account of the analytic process, such as how the data has been coded (Charmaz, 2014). In grounded theory, theoretical sampling can be implemented to assist the direction of where to go with the data (Charmaz, 2014). This allows room to explore additional empirical examination as the process of collected more data, new thoughts could materialise creating a new direction with the emergent information (Charmaz, 2014). This process requires to sample until no new data emerges, reaching saturation (Charmaz, 2014).

Upon gaining participant consent, the audio recording will be transcribed following the interviews and placed in a restricted folder on UWE OneDrive and anonymity will be maintained. Alongside this, a documentation for the data will be managed by providing information on the dates, purpose of the data, the researcher, details of how the data was created and analysed, as well as any explanation of how codes and abbreviations were used and will be kept with the data files to aid interpretation and findings. The data key will be kept separately to ensure participant confidentiality, stored with encryption on UWE OneDrive. I will have access to the audio recordings and my supervisors will have access to the transcriptions that will be stored on UWE OneDrive with an encryption key. The audio recordings will be filed until the analysis is complete, anonymity will be provided and grounded theory will be used to analyse the data following Charmaz's (2014) constructivist grounded theory.

Due to the current global conditions of Covid-19, it's important to consider how the interview process might be impacted, thus modifying the methods of interviewing. The use

of online programmes will be used to conduct interviews. This will require careful consideration of the impact of doing interviews virtually. Some participants' might find accessing a private space difficult, building rapport can be tricky with internet connection (Shaw, 2010), artificial, environmental distractions – all of which may impact the depth and quality of information received (Jowett, Peel & Shaw, 2011). Therefore, there will be attempts to ensure more time is available for each participant to allow room for any unplanned challenges. The research will utilise UWE Ethics and BPS Code of Ethics and Conduct (2018), ensuring privacy (Appendix B), autonomy, consent (Appendix A) and debriefing. In the case of distress, withdrawal will be ensured/ prepared up to 15 days post-interview, as well as support resources for the participant to ensure their safety.

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Section 3: Human Participants'	
Does the project involve human participants' or their data? If not, please proceed to Section 5: Data Collection, Storage and Disposal, you do not need to complete sections 3-4.	Yes
Section 3.1: Participant Selection	
Who are your participants'?	
The participants' are required to be Muslim, between the age of 18-25 who have not suffered from any severe mental health issues that would not render their ability to consent.	
Will you be recruiting students as research participants' who are from outside your faculty and/or from multiple faculties? If you plan to recruit student participants' from across UWE (rather than solely from your home faculty) your ethics application will be reviewed by UREC instead of the FREC.	No
Please explain the steps you will take to select your participant sample.	
The participants' that will be recruited for this study would be accessing the Muslim population. To recruit the participants', they will need to be informed about the research through advertisements. This will be through putting notices in populated Muslim areas in Bristol, such as Eastville, East London and Wales by distributing notices to mosques by contacting Imam's who may have connections to potential participants' to help in recruitment (Braun, 2000). I will use social media platforms to post the advertisements as Covid-19 may cause further restrictions, therefore posting on community Muslim pages on Facebook and Instagram as well as LinkedIn for a wider reach.	

Charities such as Inspirited Minds (Muslim mental health services) could also provide accessibility to potential participants'. There is the possibility that these strategies of recruitment would require additional time volunteering or participation in charity events to express thank you (Braun, 2008). I will be emailing the administrators of the online platforms as well as charities and mosques in order to gain approval to post or acquire participants' using their services. There will be careful consideration to posting online in order to disable tags and comments under posts to protect confidentiality or any disclosure of identifiable information.

Please explain how you will determine the sample size.

I have used Charmaz (2014) sample size recommendation as it can produce a lasting significance. However, it is important to pay heed to saturation of data, which is seen as the 'gold standard' for regulating sample size in qualitative research (Morse, 2015). Saturation refers to no additional data being identified for the researcher to create new coding. When similar themes are produced consistently, the researcher is ensured that the data is saturated (Glaser & Strauss, 2017). Saturation here is connected to theoretical sampling, whereby the sampling is channelled by 'similarities and contrasts required' by the developing theory (Dey, 1999) resulting in the combination of sampling, data collection and analysis, as opposed to addressing them as part of a linear process (Baker, 2012). Consequently, there is room for more participants' to be recruited until no new patterns of conceptualisation appear. Thus, starting with 15 participants' will be required to fit this criterion (Fusch & Ness, 2015).

References:
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Please tell us if any of the participants' in your sample are vulnerable, or are potentially vulnerable and explain why they need to be included in your sample.
NB: Please do not feel that including vulnerable, or potentially vulnerable participants' will be a bar to gaining ethical approval. Although there may be some circumstances where it is inappropriate to include certain participants', there are many projects which need to include vulnerable or potentially vulnerable participants' in order to gain valuable research information. This particularly applies to projects where the aim of the research is to improve quality of life for people in these groups.

Vulnerable or potentially vulnerable participants' that you must tell us about:
Children under 18
Adults who are unable to give informed consent
Anyone who is seriously ill or has a terminal illness
Anyone in an emergency or critical situation
Anyone with a serious mental health issue that might impair their ability to consent, or cause the research to distress them
Young offenders and prisoners
Anyone with a relationship with the researcher(s)
The elderly

I am aiming to recruit participants' at the age of 18 or above. My exclusion criteria will be anyone who has struggled with mental health that renders them unable to consent. For my research, I am aiming to recruit participants' who do not fit the vulnerability criteria.
There may be the possibility that a participant is vulnerable without foreknowledge, in which case all participants' will be provided with resources to ensure their safety: psychologically, emotionally

and physically, such as counselling or helplines and will be withdrawn from the study. Participants' can also withdraw from the interviews if they experience any distress before, during and after the interview.
Section 3.2: Participant Recruitment and Inclusion
How will you contact potential participants'? Please select all that apply.
☒ Advertisement ☒ Emails ☒ Face-to-face approach ☐ Post ☒ Social media ☐ Telephone calls ☐ Other If Other, please specify: Click or tap here to enter text.
What recruitment information will you give potential participants'? Please ensure that you include a copy of the initial information for participants' with your application. Research Template Participant Information Sheet Research Template Privacy Notice
See Appendix C – Participant Information Sheet
How will you gain informed written consent from the participants'? Please ensure that you include a copy of the participant information sheet and consent form with your application. Research Template Consent form Research Template Privacy Notice
See Appendix A – Consent Form The information and consent forms will be discussed and agreed before the start of the interviews.
What arrangements are in place for participants' to withdraw from the study?
Participants' will have access to my contact details, email address and phone number should they wish to withdraw. This will be available between the time of data collection up until one 15 days post-data collection.

Section 4: Human Tissue	
Does the project involve human tissue?	No
If you answer 'No' to the above question, please go to Section 5 Please describe the research methodology that you will use. This should include an explanation of why human tissue is required for the project and a description of the information that you and the research team will have access to about the participants'/donors.	
Click or tap here to enter text.	
Please describe how you propose to obtain/collect, process, securely store and dispose of the human tissue.	
Click or tap here to enter text.	
Please explain if and how samples will be anonymised. Where samples are not anonymised, please explain how confidentiality will be maintained, including how this information will be securely and appropriately stored and disposed of.	
Click or tap here to enter text.	

Section 5: Data Collection, Storage and Disposal
Research undertaken at UWE by staff and students must be GDPR compliant. For further guidance see Research and GDPR compliance ☒Please confirm that you have included the UWE Privacy Notice with the Participant Information Sheet and Consent Form ☒ By ticking this box, I confirm that I have read the Data Protection Research Standard, understand my responsibilities as a researcher and that my project has been designed in accordance with the Standard.

Section 5.1 Data Collection and Analysis
Which of these data collection methods will you be using? Please select all that apply.
☒ Interviews ☐ Questionnaires/surveys ☐ Focus groups ☐ Observation ☐ Secondary sources ☐ Clinical measurement ☐ Digital media ☐ Sample collection ☐ Other If Other, please specify: Click or tap here to enter text. Please note that online surveys must only be administered via Qualtrics Please ensure that you include a copy of the questionnaire/survey with your application.
What type of data will you be collecting?
☐ Quantitative data ☒ Qualitative data
Please describe the data analysis and data anonymisation methods.

The participant information would be anonymised at all times in order to ensure that they are not identifiable. The participants' data will be protected by implementing pseudonym in place of their name. Any identifiable information such as place of worship, work or home will not be included, instead there will be an indication in the transcription that identifiable information has been removed. I will ensure that I fork through this information and consult with my supervisors in the process to ensure that the participant anonymity is of utmost importance.
Section 5.2 Data Storage, Access and Security
Where will you store the data? Please select all that apply.
☐ H:\ drive on UWE network ☐ Restricted folder on S:\ drive ☒ Restricted folder on UWE OneDrive ☒ Other (including secure physical storage) If Other, please specify: Encrypted USB – destroyed as soon as all necessary information has been transcribed.
Please explain who will have access to the data.
I will have access to the audio recordings only. My supervisors; Dr. Eva Fragkiadaki and Nigel Williams and I will have access to the transcriptions
Please describe how you will maintain the security of the data and, where applicable, how you will transfer data between co-researchers.
The data will be secured and shared on one-drive where the data can be shared with password protected folders with Eva and Nigel who will only have access to transcripts.
Section 5.3 Data Disposal
Please explain when and how you will destroy personal data.
Any personal data will be removed upon completion through deleting the files, as well as ensuring that all identifiable information has been removed in the transcripts. The hard copies will be disposed safely using UWE's confidential paper disposal.

Section 6: Other Ethical Issues
What risks, if any, do the participants' (or donors, if your project involves human tissue) face in taking part in the project and how will you address these risks?
Due to individual differences, the nature of the topic may be sensitive to participants', exposing them to potential distress when discussing experiences from the past and the presence which is a risk. During my screening for participants', I won't be selecting participants' who are known to have underlying mental health issues but as that will be difficult to guarantee, I will be using my skills from my training to manage any risks that arise. The participants' will be provided with a follow-up check-in and resources that can be contacted post-interviews for additional support. The participants' will also be fully debriefed before, during and after the interview process to give them as much support as I can. It is important for me to consider how this may be heightened during the recent global pandemic (Covid-19) and the way it may have had an effect on each individual life, emotionally and physically, thus taking into consideration the way in which support can be provided on an individual basis. Participants' will be reminded that they are able to withdraw any time during the interview and up to 15 days post-interview day whilst transcriptions are being produced.
Are there any potential risks to researchers and any other people as a consequence of undertaking this project that are greater than those encountered in normal day-to-day life? For further information, see guidance on safety of social researchers.
No
How will the results of the project be reported and disseminated? Please select all that apply.

☒ Peer reviewed journal ☒ Conference presentation ☐ Internal report ☒ Dissertation/thesis ☐ Written feedback to participants' ☐ Presentation to participants' ☐ Report to funders ☐ Digital media ☐ Other If Other, please specify: Click or tap here to enter text.

Does the project involve research that may be considered to be security sensitive? For further information, see UREC guidance for security sensitive research.	No
Please provide details of the research that may be considered to be security sensitive.	
Click or tap here to enter text.	
Does the project involve conducting research overseas?	No
Have you received approval from your Head of Department/Associate Dean (RKE) and is there sufficient insurance in place for your research overseas?	Choose an item.
Please provide details of any ethical issues which may arise from conducting research overseas and how you will address these.	
Click or tap here to enter text.	

Section 7: Supporting Documentation
Please ensure that you provide copies of all relevant documentation, otherwise the review of your application will be delayed. Relevant documentation should include a copy of: • The research proposal or project design. • The participant information sheet and consent form, including a UWE privacy notice. • The questionnaire/survey. • External ethics approval and any supporting documentation. Please clearly label each document - ensure you include the applicant's name, document type and version/date (e.g. Joe Bloggs - Questionnaire v1.5 191018).

Section 8: Declaration
☒ By ticking this box, I confirm that the information contained in this application, including any accompanying information is, to the best of my knowledge, complete and correct. I have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the right of the participants'. Name: Iman Idjer Date: 14/07/2020

This form should be submitted electronically to the Research Ethics Admin Team: researchethics@uwe.ac.uk and email copied to the Supervisor/Director of Studies where applicable, together with all

supporting documentation (research proposal, participant information sheet, consent form etc).
Please provide all the information requested and justify where appropriate.
For further guidance, please see
http://www1.uwe.ac.uk/research/researchethics (applicants' information)

Appendix B
Risk Assessment Form

University of the West of England
BRISTOL

GENERAL RISK ASSESSMENT FORM

Ref:

Describe the activity being assessed: Interviews will be conducted to explore the ways the culture and religion have an influence on mental health perceptions in Muslim young people (18-25 year olds).	**Assessed by:** Dr. Eva Fragkiadaki	**Endorsed by:** Dr. Zoe Thomas
Who might be harmed: Participant and Researcher **How many exposed to risk:** 10-15	**Date of Assessment:**	**Review date(s):**

Hazards Identified ***(state the potential harm)***	**Existing Control Measures**	**S**	**L**	**Risk Level**	**Additional Control Measures**	**S**	**L**	**Risk Level**	**By whom and by when**	**Date completed**
Safeguarding the participant in the case of disclosing information that may be used to identify the participant which will be omitted from the transcripts.	Confidential information will be kept confidential as the recordings will only be heard by the researcher, and when the audio recordings have been transcribed they will then be shared with my supervisors. Participants will also be given 15 days post-interview to withdraw from the study before transcription takes place.	1	1	1						
Lone-working with participants – risk to researcher – working online.	The researcher will make sure that her supervisor is aware of any meetings that are to occur. Thee research will be checked for its appropriateness of the research (accessibility, privacy, safety) for the participant and researcher when conducting interviews online.	1	1	1						
Some of the content discussed may be distressing to the	As highlighted in the Participant Information Sheet, services and resources will be provided for the	1	2	2						

participant during the interview	participants to access after the research interviews are conducted if the participant is experiencing distress. There will be a debrief before and after the interview to ensure that the participant is okay, followed by signposting to the resources mentioned above. The contact details of the researcher and supervisor will be provided in the Participant Information Sheet, should the participant need it. Participants will be reminded before, during and after the interview that they have the right to withdraw and that option is available for them, until 15 days post-interview.									
Covid-19 restrictions may mean that face-to-face interviews may not happen, thus resorting to online interviews via zoom or skype. This could be problematic due to privacy, triggering environments	As Covid-19 continues, interviews will be conducted using online platforms to minimise the risk of contamination. This would also need consideration for ensuring that the participant has enough privacy and freedom to talk, this may differ from participant to participant. Participants will be reminded of their right to withdraw should online platforms be unmanageable for the participant.	1	1	1						

RISK MATRIX: (To generate the risk level).

Very likely 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Extremely unlikely 1	1	2	3	4	5
Likelihood (L) ↑ / → Severity (S)	Minor injury – No first aid treatment required 1	Minor injury – Requires First Aid Treatment 2	Injury - requires GP treatment or Hospital attendance 3	Major Injury 4	Fatality 5

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	RISK LEVEL:	ACTION:
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary
20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

Appendix C
Consent Form

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

You are invited to take part in this research that is looking at the cultural and religious influences on developing mental health perceptions in young people. I am interested in gaining insight into your unique outlooks, understanding and experiences of this topic.

If you are happy to take part in this interview, please sign and date the form. You will be given a copy to keep for your records.

By signing the consent form, I agree that:

- I have read and understood the information in the Participant Information Sheet which I have been given to read before asked to sign this form;
- I have been given the opportunity to ask questions about the study;
- I have had my questions answered satisfactorily by the research team;
- I agree that anonymised quotes may be used in the final Report of this study;
- I understand that my participation is voluntary and that I am free to withdraw up to 15 days post-interview until the data has been anonymised, without giving a reason;
- I understand that the data will be kept anonymous and confidential
- I agree to take part in the research

Name (Printed)…….

Signature……. Date…….

Appendix D
UWE Privacy Notice

Privacy Notice for Research Participants'

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

Purpose of the Privacy Notice

This privacy notice explains how the University of the West of England, Bristol (UWE) collects, manages and uses your personal data before, during and after you participate in this study that looks at Cultural and Religious influences on your mental health perceptions. 'Personal data' means any information relating to an identified or identifiable natural person (the data subject). An 'identifiable natural person' is one who can be identified, directly or indirectly, including by reference to an identifier such as a name, an identification number, location data, an online identifier, or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

This privacy notice adheres to the General Data Protection Regulation (GDPR) principle of transparency. This means it gives information about:

- How and why your data will be used for the research;
- What your rights are under GDPR; and
- How to contact UWE Bristol and the project lead in relation to questions, concerns or exercising your rights regarding the use of your personal data.

This Privacy Notice should be read in conjunction with the Participant Information Sheet and Consent Form provided to you before you agree to take part in the research.

Why are we processing your personal data?

UWE Bristol undertakes research under its public function to provide research for the benefit of society. As a data controller we are committed to protecting the privacy and security of your personal data in accordance with the (EU) 2016/679 the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (or any successor legislation) and any other legislation directly relating to privacy laws that apply (together "the Data Protection Legislation"). General information on Data Protection law is available from the Information Commissioner's Office (https://ico.org.uk/).

How do we use your personal data?

We use your personal data for research with appropriate safeguards in place on the lawful bases of fulfilling tasks in the public interest, and for archiving purposes in the public interest, for scientific or historical research purposes.

We will always tell you about the information we wish to collect from you and how we will use it.

We will not use your personal data for automated decision making about you or for profiling purposes.

Our research is governed by robust policies and procedures and, where human participants' are involved, is subject to ethical approval from either UWE Bristol's Faculty or University Research Ethics Committees. This research has been approved by the Faculty Research Ethics Committee (FREC) at UWE.

The email address to contact for any queries or complaints is: researchethics@uwe.ac.uk.

The research team adhere to the **Ethical guidelines of the British Educational Research Association (and/or the principles of the Declaration of Helsinki, 2013) and the principles of the General Data Protection Regulation (GDPR).**

For more information about UWE Bristol's research ethics approval process please see our Research Ethics webpages at:
www1.uwe.ac.uk/research/researchethics

What data do we collect?

The data we collect will vary from project to project. Researchers will only collect data that is essential for their project. The specific categories of personal data processed are described in the Participant Information Sheet provided to you with this Privacy Notice. We will collect information such as your age, ethnicity, culture, experiences and mental health perceptions.

Who do we share your data with?

We will only share your personal data in accordance with the attached Participant Information Sheet and your Consent.

How do we keep your data secure?

We take a robust approach to protecting your information with secure electronic and physical storage areas for research data with controlled access. If you are participating in a particularly sensitive project UWE Bristol puts into place additional layers of security. UWE Bristol has Cyber Essentials information security certification.

Alongside these technical measures there are comprehensive and effective policies and processes in place to ensure that users and administrators of information are aware of their obligations and responsibilities for the data they have access to. By default, people are only granted access to the information they require to perform their duties. Mandatory data

protection and information security training is provided to staff and expert advice available if needed.

How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research. The length of time we keep your personal data will depend on several factors including the significance of the data, funder requirements, and the nature of the study. Specific details are provided in the attached Participant Information Sheet. Anonymised data that falls outside the scope of data protection legislation as it contains no identifying or identifiable information may be stored in UWE Bristol's research data archive or another carefully selected appropriate data archive.

Your rights and how to exercise them

Under the Data Protection legislation you have the following **qualified** rights:

(1) The right to access your personal data held by or on behalf of the University;
(2) The right to rectification if the information is inaccurate or incomplete;
(3) The right to restrict processing and/or erasure of your personal data;
(4) The right to data portability;
(5) The right to object to processing;
(6) The right to object to automated decision making and profiling;
(7) The right to complain to the Information Commissioner's Office (ICO).

Please note, however, that some of these rights do not apply when the data is being used for research purposes if appropriate safeguards have been put in place.

We will always respond to concerns or queries you may have. If you wish to exercise your rights or have any other general data protection queries, please contact UWE Bristol's Data Protection Officer (dataprotection@uwe.ac.uk).

If you have any complaints or queries relating to the research in which you are taking part please contact either the research project lead, whose details are in the attached Participant Information Sheet, UWE Bristol's Research Ethics Committees (research.ethics@uwe.ac.uk) or UWE Bristol's research governance manager (Ros.Rouse@uwe.ac.uk)

Appendix E
Participant Information Sheet

Participant Information Sheet

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

Who are the researchers and what is the research about?
Thank you for your interest in this research on Cultural and Religious Influences on the development of mental health perceptions in Muslim young people. My name is Iman Idjer and I am a student on the Doctorate of Counselling Psychology Programme at the University of the West of England, Bristol. I am completing this research for my thesis project. My research is supervised by Dr. Eva Fragkiadaki.

What does participation involve?
You are invited to participate in an interview where you will be asked a series of questions to answer in your own words. The interview will cover questions around religion, culture and mental health perceptions. The interview will be audio recorded and I will transcribe (type-up) the interview for the purpose of analysis. At the start of the interview, I will ask you to read and sign a consent form. You will also be asked to complete a short demographic questionnaire. This will provide me with an understanding of who is taking part in the research. I will discuss what is going to happen in the interview and you will be given the opportunity to ask any questions you might have. You will also have another opportunity to ask any questions at the end of the interview.

Who can participate?
Anyone between the ages of 18-25 who is interested in taking part.

How will the data be used?
Your interview data will be anonymised (i.e., any information that can identify you will be removed) and analysed for my research project. This means extracts from your interview may be quoted in my thesis and in any publications and presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.

What are the benefits of taking part?
Taking part in this research will enrich the services in the field, expanding and catering for individuals who may feel marginalised or underrepresented in mental health services.

How do I withdraw from the research?
If you decide you want to withdraw from the research please contact me via email: iman2.idjer@live.uwe.ac.uk. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me within 15 days of

participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

Are there any risks involved

We don't anticipate any particular risk to you with participating in this research; however, there is always the potential for research participant to raise uncomfortable and distressing issues. For this reason we have provided information about some of the different resources which are available to you. If you are a UWE student you can also use the university counselling services, see http://www1.uwe.ac.uk/students/healthandwellbeing/wellbeingservice.aspx or email wellbeing@uwe.ac.uk, or telephone 0117 3286268.

If you are not a student at UWE or you would prefer an off campus counselling service the following website lists free or low cost counselling services in the local area: http://www.bristolmind.org.uk/bsn/counselling

Some additional resources recommended by the NHS are:

Anxiety UK

Charity providing support if you have been diagnosed with an anxiety condition.
Phone: 03444 775 774 (Monday to Friday, 9.30am to 10pm; Saturday to Sunday, 10am to 8pm)
Website: www.anxietyuk.org.uk

Mental Health Foundation

Provides information and support for anyone with mental health problems or learning disabilities.
Website: www.mentalhealth.org.uk

Mind

Promotes the views and needs of people with mental health problems.
Phone: 0300 123 3393 (Monday to Friday, 9am to 6pm)
Website: www.mind.org.uk

Samaritans

Confidential support for people experiencing feelings of distress or despair.
Phone: 116 123 (free 24-hour helpline)
Website: www.samaritans.org.uk

SANE

Emotional support, information and guidance for people affected by mental illness, their families and carers.
SANEline: 0300 304 7000 (daily, 4.30pm to 10.30pm)
Textcare: comfort and care via text message, sent when the person needs it most: www.sane.org.uk/textcare
Peer support forum: www.sane.org.uk/supportforum
Website: www.sane.org.uk/support

YoungMinds

Information on child and adolescent mental health. Services for parents and professionals.
Phone: Parents' helpline 0808 802 5544 (Monday to Friday, 9.30am to 4pm)

Website: www.youngminds.org.uk

Contacts:
If you have any questions about these research please contact me using my email below:
Iman Idjer: iman2.idjer@live.uwe.ac.uk

Supervisor email:
Email: eva.fragkiadaki@uwe.ac.uk

Ethics
The project has been reviewed and approved by UWE Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at: Researchethics@uwe.ac.uk

Thank you for agreeing to take part in this study.

You will be given a copy of this Participant Information Sheet and your signed Consent Form to keep.

Appendix F
Demographics Form

Demographics Form

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

How old are you?
I am: Female ☐ Male ☐ Other _____
How do you describe your sexuality? Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual ☐ Asexual ☐ Other _____
How do you describe your ethnicity? (E.g., White British or British Asian, Black Caribbean)
Do you consider yourself to be a Muslim? Yes ☐ No ☐
Do you practice praying (salat) regularly? Yes ☐ No ☐
Have you used any mental health services before? Yes ☐ No ☐
Have you had any experience/ knowledge of mental health services, counselling psychological support, previously?

Appendix G
Interview Protocols

Preliminary Questions 1

Preliminary Interview Questions

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

Introduction

Good Morning/ Afternoon, my name is Iman. Thank you for taking part in my research. The interview questions will be enquiring about cultural and religious influences that may have an impact on mental health perceptions of young Muslim people.

If there are any questions that you do not want to answer, please let me know and we will move onto the next question. You can leave the interview at any time, and you can withdraw from this research up to 15 days after this interview.

Do you have any questions for me before we begin?

Questions

1. How would you describe your religion?
    a. What does your religion mean to you?
    b. Are there any religious practices you deem helpful when you are faced with difficulty?
    c. Can you tell me what your day to day religious practice looks like?
2. How would you describe your culture?
    a. Do you consider yourself cultural, religious or both?
    b. How does this influence your daily life?
    c. Does this differ with other people versus on your own?
3. How do you understand mental health?
    a. Have you had any experiences that influence your opinion?
    b. When did you first come into contact with mental health?
    c. Has your idea of mental health changed over time?

Preliminary Questions 2

Reviewed Questions:

1. Tell me about your religion, how you came to it?
    a. When, if at all did you start practicing your religion?
        i. If so, what was it like? If you recall, what were you thinking then?
        ii. Who, if anyone, influenced you? Tell me about how she/he influenced you?
    b. Could you describe the events that led up to you practicing your religion?
    c. What contributed to your ideas around religion?
    d. Are there any religious practices you deem helpful when you are faced with difficulty?

---

        i. Can you tell me what your day-to-day religious practice looks like? Could you describe a typical day when you are practicing?
    e. Are there any religious practices you deem unhelpful when faced with difficulty?
2. Tell me about your culture? How would you describe it?
    a. Do you consider yourself cultural, religious or both?
    b. How does this influence your daily life?
    c. What are the positives that culture brings to your life?
    d. What are the negatives that culture brings to your life?
    e. Does this differ with other people versus your own?
3. What, if anything, did you know about mental health?
    a. Could you tell me your thoughts and feelings when you learned about mental health?
    b. Who, if anyone, was involved? When was that? How were they involved?
    c. What contributed to your ideas around mental health?
    d. How, if at all, have your thoughts and feelings about mental health changed?
    e. As you look back on your mental health perspective, are there any other events that stand out in your mind/ perspectives that you held? Could you describe it? How did this event affect what happened? How did you respond to it?
    f. What helps you to manage your mental health? What problems might you encounter?
    g. What has been the most helpful to you during this time? How has he/she been helpful?
    h. Has any organization been helpful? What did it help you with? How has it been helpful?
    i. What do you think are the most important ways to support young peoples mental health? How has your experience before mental health awareness affected how you handled it?
    j. Is there something that you might not have thought about before that occurred to you during this interview?
    k. Is there something else you think I should know to understand your perspective better?
    l. Is there anything you would like to ask me?

Preliminary Questions 3

Preliminary Interview Questions

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

Introduction

Good Morning/ Afternoon, my name is Iman. Thank you for taking part in my research. The interview questions will be enquiring about cultural and religious influences that may have an impact on mental health perceptions of young Muslim people.

If there are any questions that you do not want to answer, please let me know and we will move onto the next question. You can leave the interview at any time, and you can withdraw from this research up to 15 days after this interview.

Do you have any questions for me before we begin?

Interview Schedule

1. What, if anything, do you know about mental health?
    a. Who if anyone helped you learn about mental health?
    b. As you look back on your mental health perspective, are there any events that stand out in your mind that have resulted in the way you view mental health now?
2. Could you tell me about your religion and how you came to it?
    a. Was there anyone, who influenced you in your religious beliefs?
    b. What contributed to your ideas around religion?
    c. Through the lens of religion, what is the perception of gender and mental health?
    d. Through the lens of religion, how does family perceive mental health?
    e. What is your perspective on stigma of mental health through the lens of religion?
    f. Are there any religious practices that you deem helpful when you are facing difficulty?
    g. Are there any religious practices that you deem unhelpful when you are faced with difficulty?
3. Could you tell me a bit about your culture and how would you describe it?
    a. Do you consider yourself cultural, religious or both?
    b. Do you feel there is a difference between religion and culture?
    c. Through the lens of culture, what is the perception of gender and mental health?
    d. Through the lens of culture, how does family perceive mental health?
    e. What is your perspective on stigma of mentl health through the lens of culture?
    f. What are the positives that culture brings to your life?
    g. What are the negatives that culture brings to your life?
4. What do you think are some important ways to help Muslim young people's mental health?
5. Is there anything you would like to add that would help understand your perspective better?

Preliminary Questions 4

Preliminary Interview Questions

Cultural and Religious Influences in developing mental health perceptions in Muslim young people: A Grounded Theory Research.

Introduction

Good morning/ Afternoon, my name is Iman. Thank you for taking part in my research. The interview questions will be enquiring about cultural and religious influences that may have an impact on mental health perceptions of young Muslim people.

If there are any questions that you do not want to answer, please let me know and we will move onto the next question. You can leave the interview at any time, and you can withdraw from this research up to 15 days after this interview.

Do you have any questions for me before we begin?

We can spend some time getting to know each other before we begin.

Can you tell me a little bit about yourself?

Record on device – everything will only be heard by myself, and once I've transcribed it, it will only be read by my supervisors and then the recording itself will be deleted. If at any point you need a break or need to stop, please feel free to say so and of course if you no longer want to take part that is also okay.

I also will mainly be reading the questions so feel free to add anything and everything that you are comfortable sharing – no right or wrong answer and I'm just interested in your perspective and feel free to give examples on anything that comes to mind with what I ask

Interview Schedule

1. What, if anything, do you know about mental health?
    a. Can you tell me your thoughts and feelings when you learnt about mental health?
    b. Who if anyone helped you learn about mental health?
    c. What are some of the ways mental health is recognised in your life?
    d. As you look back on your mental health perspective, are there any events that stand out in your mind that have resulted in the way you view mental health now?
2. Could you tell me about your religion and how you came to it?
    a. Was there anyone in particular who influenced your religious beliefs?
    b. What contributed to your ideas around religion?
    c. What is your perspective on stigma of mental health through the lens of religion?
        i. Are there any gender differences regarding this?
    d. Are there any religious practices that you deem helpful when you are faced with difficulty?
    e. Are there any religious practices you deem unhelpful when faced with difficulty?
3. Could you tell me a bit about your culture and how you would describe it?
    a. What are some of the ways that culture influences your life?
        i. How do you balance various cultural practices with religious practice?

        ii. What is your perspective on your identity through the lens of culture and religion?
    b. Do you consider yourself cultural, religious or both?
    c. Do you feel there is a difference between culture and religion?
    d. What is your perspective of stigma of mental health through the lens of culture?
        i. Are there any gender differences regarding this?
    e. What are the positives that culture brings to your life?
    f. What are the negatives that culture brings to your life?
4. What do you think are some of the important ways to help young people's mental health?
5. Is there anything you would like to add to understand your perspective better?

Appendix H

Advertisement for Recruitment

Salaamualaikum,

I am looking for participants' between the ages of 18-25 to take part in my research on Young Muslim Peoples Mental Health Perceptions.

I will be conducting an interview asking a few questions just to gain an insight on how mental health is viewed.

To fit the criteria:

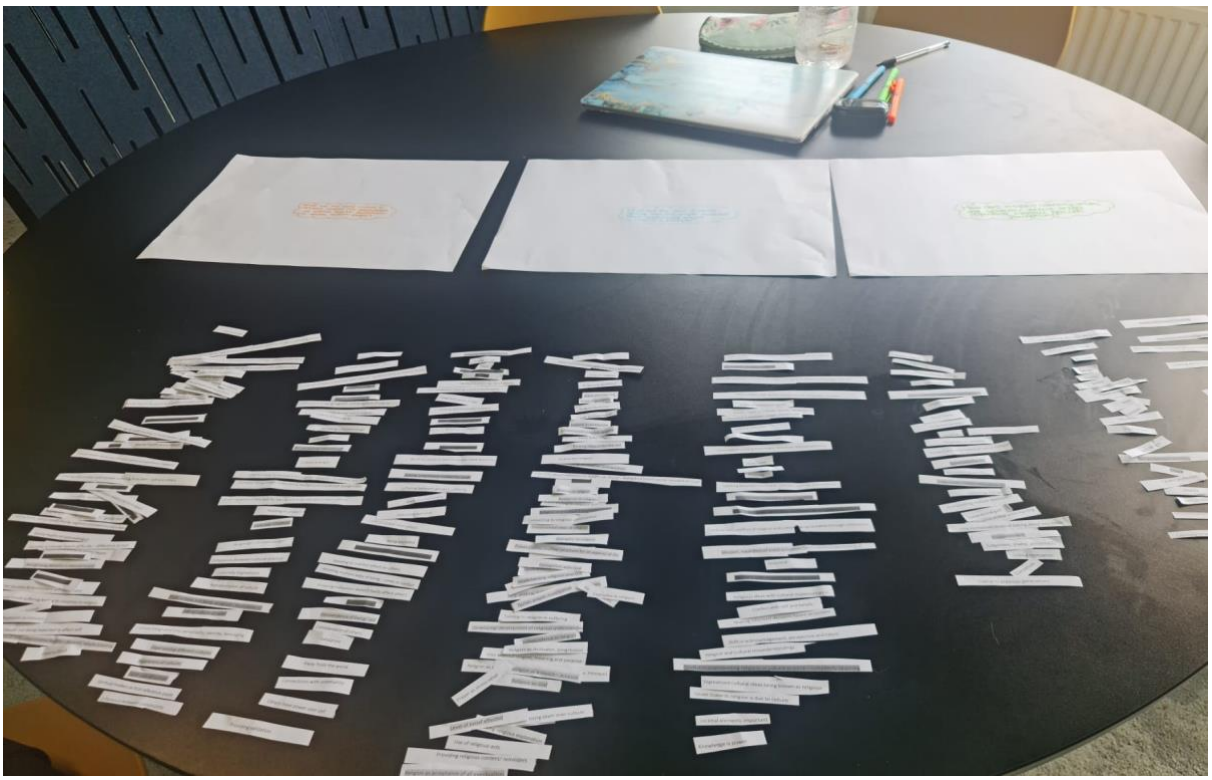
Between age of 18-25

Identify as Muslim

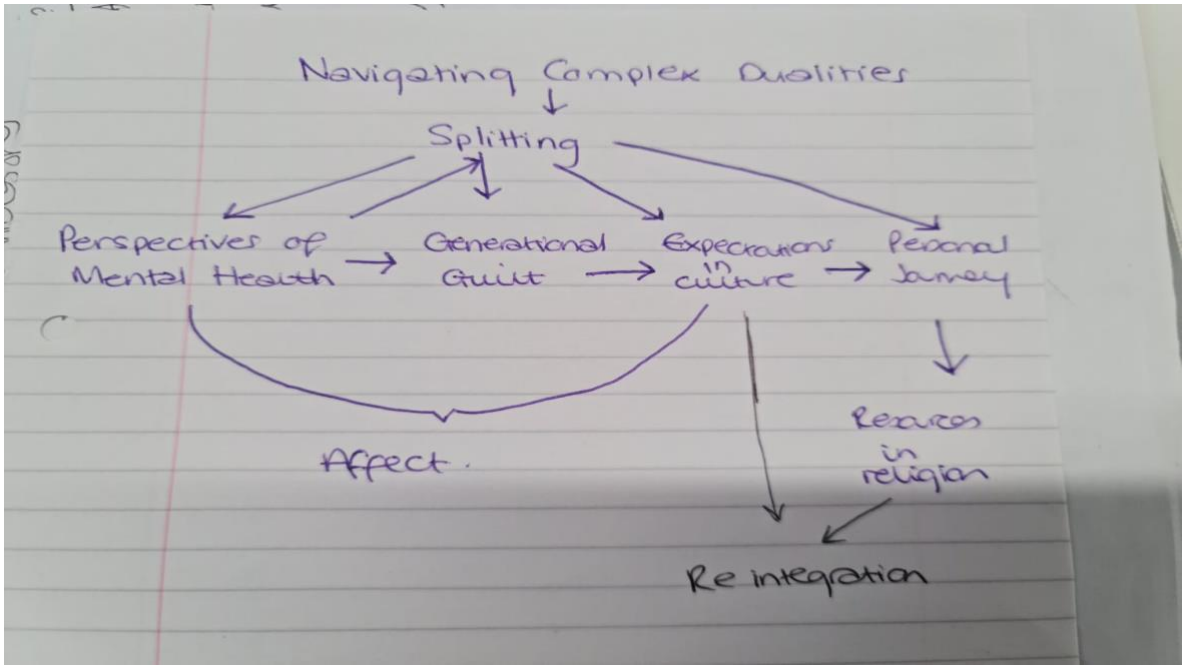
Appendix I

Images of Categorising Themes

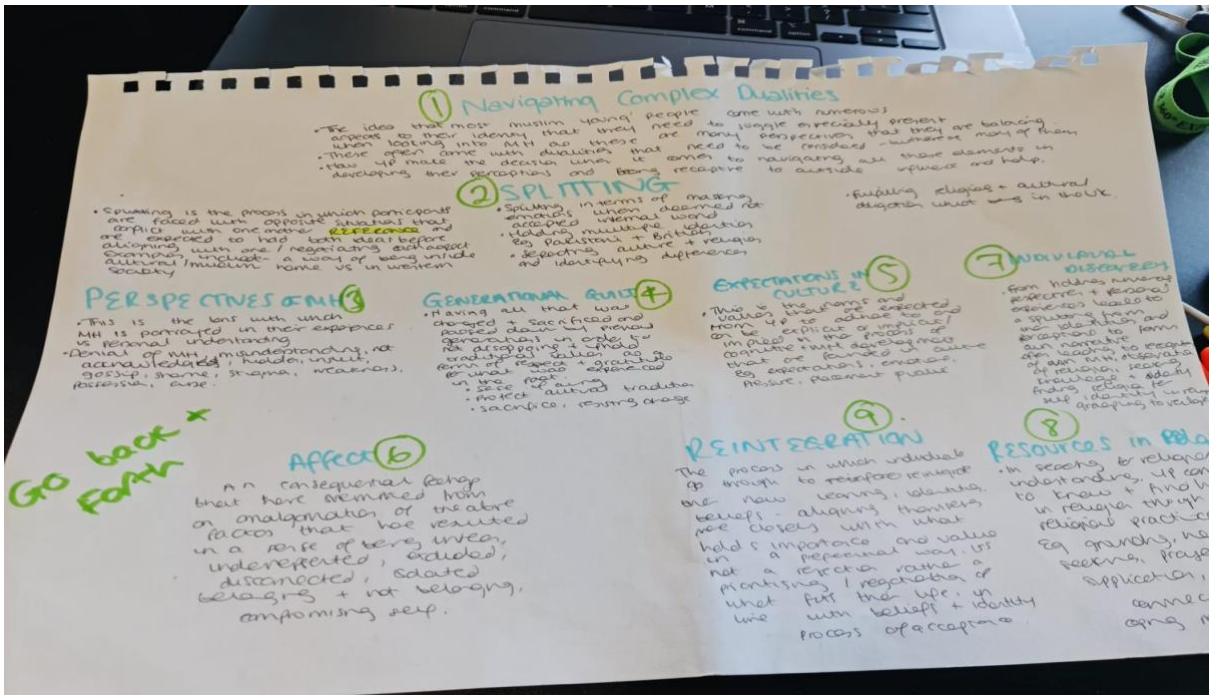
Organising Themes



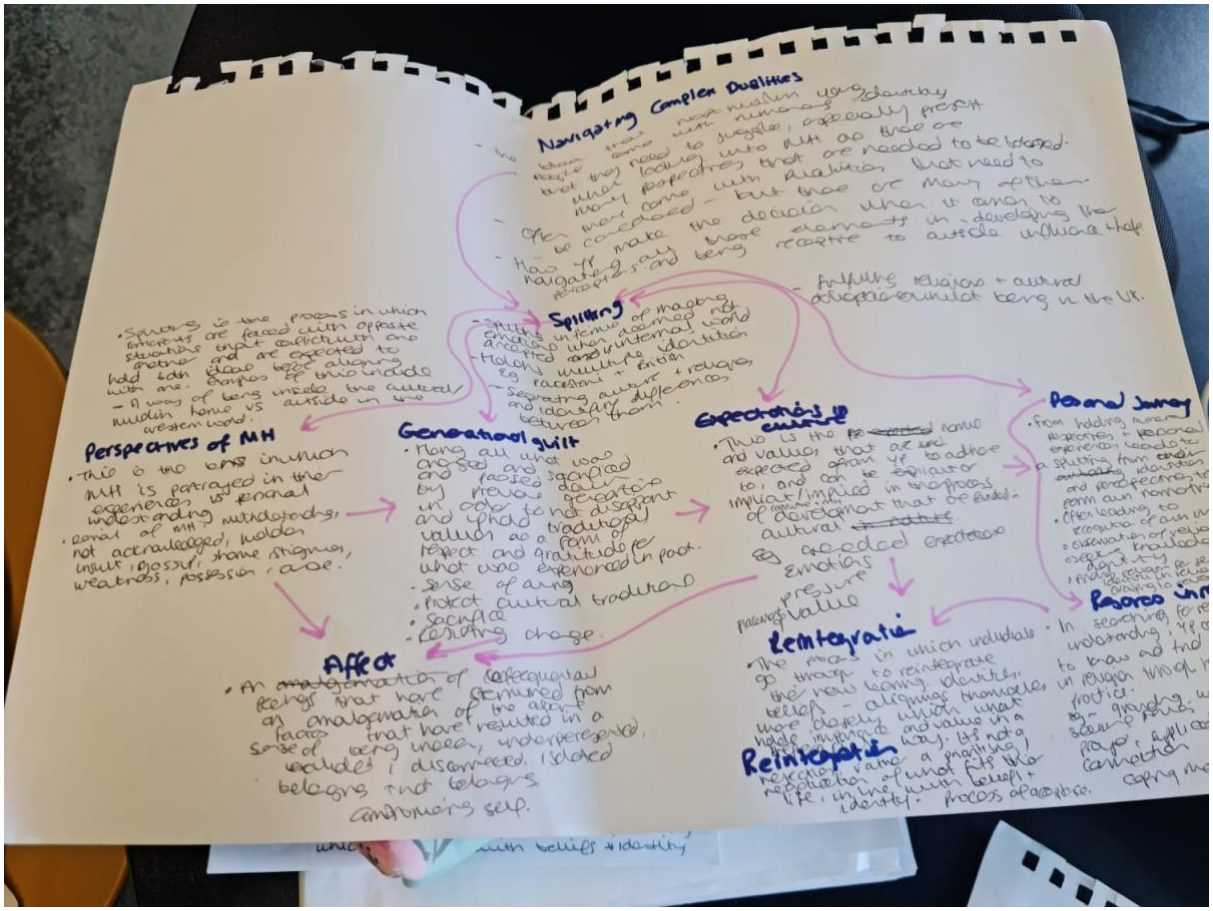
Initial Emergence of Theory



Initial Description of Categories



Exploring Themes Connections


Navigating Complex Dualities
Splitting
Perspectives of MH
Generational guilt
Affect
Reintegration
Reintegration

This figure is the original theory template.