A Qualitative Study Understanding How Mental Health Is Viewed Amongst South African Middle-adult Muslim Males

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Declaration:

I hereby declare that the Research Report submitted for the BA Honours in Psychology degree to The Independent Institute of Education is my own work and has not previously been submitted to another University or Higher Education Institution for degree purposes.

Abstract

Demonic possession, lack of faith and bad luck, these are some of ways mental health has been misconstrued in the Muslim community. The paramount influence that Islam has on how mental health is understood requires attention and rigours research. The focus of this research adopted a qualitative approach to researching how mental health is viewed amongst South African middle-adult Muslim males. Three participants fitted the specified sampling criteria and thereafter, a qualitative questionnaire was administered. Thematic analysis was employed to analyse the collected data and three themes emerged. The main theme identified was the stigmatization of mental health within the Muslim community. Historically, there has been stigmatization due to the misunderstanding of metal health. The findings that emerged was the tension between understanding mental health, treatment practices and acknowledging mental health. Therefore, further research would be required to understand how mental health is viewed in the South African Muslim community.

Key words: middle-adult, males, Muslim community, mental health

Contents

Title

A qualitative study understanding how mental health is viewed amongst South African middle-adult Muslim males.

Background

Mental health has been misunderstood in the Muslim community at large (Hamdan, 2008; Rothman & Al-Karam, 2018). The overriding impact that Islam has on mental health must be unpacked (El-Islam, 2015). Common mental health misconceptions in Islam and the South African Muslim community include lack of faith, demonic possession and bad luck (Laher & Ismail, 2012). In addition, in Muslim households, the male is generally the head of the household (Keshavarzi & Haque, 2013). Therefore, it is imperative to understand how middle-adult Muslim males view mental health. The effect of unacknowledging and misconstruing of mental health in the Muslim community results in individuals being undiagnosed and untreated (Ahmad & El-Jabali, 2015). Furthermore, these individuals are stigmatized and misunderstood int their own community (Ahmad & El-Jabali, 2015). The social cognitive theory (SCT) states that individuals replicate the behaviour of others (especially within their community or immediate surroundings) (Bandura, 1989). Therefore, it is important to understand how the Muslim community views mental health. This research aims understand how mental health viewed amongst South African middle-adult Muslim males. This research can also be used to inform the Muslim community about Mental health and can contribute to the field of Social Psychology.

Rationale

According to El-Islam (2015), lack of faith is associated with the reason behind problems in life. However, this is not the case and mental health is a real concept that affects millions of people including Muslims (Abdel-Khalek, 2011). Mental health does not discriminate (Abdel-Khalek, 2011). With this in mind, it is important to study the understanding of mental health from a South African middle-adult Muslim male perspective. Mental disorders can be treated and, in some instances, be prevented (Abdel-Khalek, 2011). There is no underlying judgment in the research, however, several Journal articles published about mental health within the Muslim and psychological realm, generally state and conclude that through prayer anything is possible (Ijaz, Khalily & Ahmad, 2017; Sulaiman & Gabadeen, 2013). According to Abu-Raiya & Pargament (2011), this points to some obstacles faced by researchers who are interested in the intersection of Islam and mental well-

being and mental health. This research topic is also worth investigating because not many studies have been done within the South African context and amongst men especially within the Muslim community (Mohamed-Kaloo & Laher, 2014; Laher, Bemath & Subjee, 2018).

Problem Statement

The influence that religion has on the understanding of mental health cannot be ignored (Ally & Laher, 2008; Weatherhead & Daiches, 2010). Spirit possession and lack of faith are understood to be the causes of obstacles in life and one of those obstacles are mental illness (Laher & Ismail, 2012). However, mental health is a complex concept that needs to be addressed from a psychological standpoint too (Abdel-Khalek, 2011). Therefore, an intersectional approach must be taken, especially with the Muslim community (Ciftci, Jones & Corrigan, 2013). Therefore, this research is aimed at understanding how South African Muslim middle-adult males view mental health with the use of a qualitative questionnaire.

Research Purpose

The purpose of the research became more apparent when reviewing South African authors works of Ally and Laher, 2008; Laher & Ismail, 2012; Mohamed-Kaloo & Laher, 2014; Laher et al., 2018. This study was aimed at understanding how mental health is viewed amongst South African middle-adult Muslim males. Upon reviewing the works of Ally & Laher, 2008; Laher and Ismail, 2012; Mohamed-Kaloo & Laher, 2014; Laher et al., 2018, an untouched area of research was found. This niche was focusing on the South African middle-adult Muslim males.

Research Question

Primary research question.

-What do South African Muslim middle-adult males understand about mental health?

Objectives

- To explore the understanding of mental health from a South African middle-adult Muslim males' perspective
- To explore how Islam has contributed to the understanding of mental health
- To explore the incorporation of psychology (mental health) and Islam.

Literature Review

This literature review section includes an explanation of the key concepts of this research. In addition, the Social Cognitive Theory (SCT) was used to explain how understanding of misconceptions is modelled and learned behaviour. Lastly, previous literature has been explored in relation to mental health, Islam and their intersectionality.

Conceptualisation

Middle-adult.

According to Erikson's stages of development (as cited in Slater, 2003), middle-adulthood is defined as the age group of 45-65 years old. This is defined as middle age (Slater, 2003). There are several developmental changes during this time, such as emotional and cognitive changes (Slater, 2003). In addition, in Islam the oldest male is generally the head of the household (Keshavarzi & Haque, 2013). Therefore, it was vital to know how these middle-adult males viewed and acknowledged mental health within their own homes.

Mental health.

Mental health is defined as a person's condition with regard to their psychological and emotional well-being (Palumbo & Galderisi, 2020). According to the World Health Organisation (as cited in Palumbo & Galderisi, 2020, p. 10), the proposed definition is, "A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Mental health within Islam.

According to Skinner (2010, p. 548), mental health within Islam involves several components of oneself, such as the "the inner self (Qalb or ''inner heart''), the intellect (Aql) and the lower drives (Nafs Amara), and the body". All of these components need to function together in order to have a healthy mind (Skinner, 2010). Mental health in Islam, acknowledges a mind and soul connection and therefore, the premise is that if the soul is unwell or troubled then the mind is also unwell and troubled (Rothman & Al-Karam, 2018). There is a strong integration of Allah (Subhanahu wa ta'ala) and the teachings of the Prophet (sallallahu alayhi wa salaam) when explaining mental health in Islam (Rothman & Al-Karam, 2018). This multifunctional approach is what is regarded as mental health in Islam (Rothman & Al-Karam, 2018).

Theoretical Foundation

Social cognitive theory

Bandura's social cognitive theory (SCT) was appropriate for this research as it states that individuals' observations affect behaviour by modelling (Bandura, 2005). This theory was created in 1986 by Albert Bandura and fell under the umbrella theory of the Social Learning Theory (Bandura, 2005). Through the process of research, Bandura found that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behaviour (Bandura, 2005). According to Bandura (2001, p. 265) SCT provides a framework to analyse "the determinants and psychosocial mechanisms through which symbolic communication influences human thought, affect and action". Psychological and social components in one's lives influence behaviours, ideas and even the construction of one's reality (Bandura, 2001).

This theory closely links to the research topic as individuals may be "self-organizing, proactive, self-reflecting, and self-regulating", they also adapt and change due to embedded social systems Bandura (2001, p. 266). Bandura (2001) goes on to mention that personal agency operates within a broad network of sociocultural influences. SCT is displayed through modelling.

Modelling.

Bandura (2001) states that there two forms of modelling displayed in SCT, direct modelling and symbolic modelling. Direct modelling is observing individual's behaviour while socially engaging (Bandura, 1989). This form of modelling is observed when individuals interact with one another (Bandura, 1989). People generally tend to model the behaviours of others while socially engaging with them (Bandura, 1989). This increases when individuals spend longer amounts of time with each other (Bandura, 1989). This modelling extends to modelling behaviours, ideas and understanding of certain concepts (Bandura, 1989). Symbolic modelling refers to individuals modelling the behaviour of those who they identify with (Bandura, 2001). This type of modelling operates on information derived from personal experiences (Bandura, 2001). Within the framework of an interactional perspective, the social cognitive theory directs much of its attention to "social origins of thought and the mechanisms through which social factors exert their influence on cognitive functioning" Bandura (2001, p. 267).

In conclusion, modelling allows individuals to feel included and be a part of the in-group, even if this means having the same ideas, beliefs and thoughts surrounding topics (Barone,

Maddux & Snyder, 2012). The in-group refers to any group which the individuals is attempting to fit into (Bandura, 2001). People have a need to feel confident that their perceptions, beliefs and feelings are correct (Bandura, 2001). In addition to this, people have a need for social approval and acceptance and often people conform to the expectations viewed as positive by others in order to avoid disapproval and/or achieve specific goals (Bandura, 2001). Individuals have the need to retain their group membership and will often conform to the views of others (Bandura, 1989). Therefore, it is useful within the context of the research as the social cognitive theory explains how individual's behaviours are regulated through reinforcement and maintained over a long period of time (Bandura, 1989). SCT along with modelling, explained how individuals acquire knowledge through certain channels, such as their friends, family members or members within their religious group and will model these behaviours just to be accepted by the in-group (Bandura, 1989).

Literature

This thematic literature review has been qualitative study on how South African middle-adult Muslim males understand various concepts of mental health. Mental health problems are common in today's society and can affect anyone irrespective of age, race and gender (Ahmad & El-Jabali, 2015; Ciftci et al., 2013). It is important to note that common mental health issues such as anxiety are increasing, not only within the Muslim society, but globally too (Ahmad & El-Jabali, 2015; Sabry & Vohra, 2013). Many individuals shy away from seeking therapy or even talking to friends and family about their mental health issues as this causes a form of stigmatization (Hankir, Pendegast, Carrick & Zaman, 2017). Even within Muslim society, Hankir et al., (2017) have reported a circle of fear surrounding individuals of the Muslim faith seeking out help. From an international perspective, Muslims are afraid to speak up as there are heightened levels of islamophobia due to the portrayal of Muslims in the media (Hankir et al., 2017). This compounds their psychological distress and fears of speaking to therapists such as psychologist or even lay counsellors (Hankir et al., 2017).

Orthodox approaches to mental health in Islam.

According to Hankir et al., (2017), Islam teaches Muslims that maintaining health and seeking treatment when necessary is an individual's duty. However, according to Inayat (as cited in Keshavarzi & Haque, 2013) there seems to be barriers to use various mental health services by Muslim clients and he goes onto highlight six factors that contribute the underutilization of these services. These factors were the "mistrust of service providers, fear of treatment, fear of discrimination, language barriers, differences in communication, and issues of culture/religion" (Hankir et al., 2017, p. 231). This is a concept that can be extended

to an international sphere and include South Africa and can be seen in the work of Laher et al., (2018).

It is often viewed from an Islamic perspective that most sicknesses are seen as a result of individuals being disconnected from God (Ghazali, 1986 as cited in Rothman & Al-Karam, 2018). While other authors see sickness as a challenge or test that people must go through in order to purify themselves and their soul. Ijaz et al., (2017) make a correlation between the mindfulness of Salah (prayer) with mental health and conclude in their study that those who pray regularly have better mental health as opposed to those who don't offer it regularly. Other authors such as Sulaiman and Gabadeen (2013, p. 47), also state that "religion is commonly relied upon to cope with the stress caused by health problems. Sulaiman and Gabadeen (2013) go on to stating various ways in which religion can assist in alleviating sickness such as Tawakkul (faith, believe or submission), Du'aa (Prayer, Supplication), recitation of the Quran, Dhikr (remembrance of God) and Tibb an-Nabawi (Prophetic Medicines). Sulaiman and Gabadeen (2013) conclude by stating that therapists and especially Muslims, must begin to realise the need for having adequate knowledge and understanding of the healing process of Islam and the importance of the various Islamic coping mechanism mentioned in dealing with all crises.

The strength of the works on Ijaz et al., (2017); Sulaiman and Gabadeen (2013), is that this approach may work for orthodox Muslim who reject the concept of western approaches of psychology. However, this approach fails to account for severe mental health disorders such as schizophrenia and other personality disorders. Authors such as El-Islam (2015); Laher et al., (2018); Rothman & Al-Karam (2018) call for the integration of Islam into psychological assistance and highlight the importance of western psychological therapies.

Integration of psychology and Islam.

Within the domain of Islam, there is a religious approach on how to understand and possibly treat mental illness. This is expanded in the works of Ijaz et al., (2017); Sulaiman & Gabadeen, (2013) who conclude that through prayer, strengthened Imaan (faith) and by the power of God, anything is possible. This research does not void faith-based practices and efforts. However, there needs to be an alternative approach if individuals require extra help through the use of psychologist, psychiatrists and through medication (Rothman & Al-Karam, 2018). There is a call for a collective understanding on how an Islamic worldview, together with professional medical help, can be practically and effectively integrated into various therapies to offer a broader range of help with those who identify as Muslim

(Hamdan, 2008; Rothman & Al-Karam, 2018). This should assist in influencing the Muslim society to seek out mental health help as they could get spiritual assistance within the parameters of psychological treatment (Hamdan, 2008). This research may repeatedly make mention to the need for an intersection of psychology and Islam. However, the main focus is the understanding of mental health amongst middle-adult South African Muslim males.

Muslim psychology and Islamic psychology.

Rothman and Al-Karam (2018) mentions of a distinction of Muslim psychology and Islamic psychology. This helps focus on various therapies that incorporates language, customs, and culturally relevant sentiments into the therapeutic process (Rothman & Al-Karam, 2018). Muslim psychology focuses on how Muslims think and behave (Rothman & Al-Karam, 2018). It is primarily a culturally adapted approach to Western therapy (Hamdan, 2008). This therapeutic technique is more relevant to a Muslim population to make "such services palatable where they may otherwise be stigmatized" (Rothman & Al-Karam, 2018, p. 26). Utz (as cited in Rothman & Al-Karam, 2018, p.26) mention that Islamic psychology is an "indigenous approach" to the study and understanding of psychology that is "informed by the teaching and knowledge from the Quran and the Prophetic tradition". An Islamic approach to psychological therapies "therapy recognizes and engages the soul in the conceptualization of the self and often focuses on the heart rather than the mind as the center of the person" (Rothman & Al-Karam, 2018, p. 26). It is important that the differences of these concepts are understood in terms of the research and understanding of context used when treating the Muslim population (Rothman & Al-Karam, 2018). Rothman and Al-Karam (2018) state that conventional psychology has become strictly about studying the brain, behaviours and personality traits, which is what constitutes the need for faith-based integrated psychology, such as Islamic psychology, where aspects such as the soul are accounted for. Religion and spiritual techniques can be used in conjunction with western psychology, to provide structure to people's understanding of themselves and their own personal growth (Hamdan, 2008).

Spiritual leader's assistance with mental health.

The work of Abu-Ras, Gheith and Cournos (2008) highlight the importance of the intersection of religion and psychology. Abu-Ras et al., (2008), proves that when a Muslim is in distress, they first turn to religion. The Imam of 22 mosques did not possess a formal education or the training in mental health or psychology, however, they assisted their congregates in whichever manner they could (Abu-Ras et al., 2008). It was thrilling to notice the progressiveness of majority of the Imams as they "expressed great eagerness to learn

Western psychotherapy methods of treatments, and believed in combining Islamic tradition with modern talk psychotherapy and medication as the most effective approach to treating people with emotional problems." (Abu-Ras et al., 2008, p. 169).

A study conducted by Ali, Milstein and Marzuk (2005) further emphasised the importance of Imams in assisting the Muslim community with all aspects of life, including personal problems and mental health. Post 9/11, Imams had received formal training in counselling so that they could assist their congregates (Ali et al., 2005). It is important to note that the Muslim community was ostracised and often ridiculed after the terror attacks (Ali et al., 2005). Many Muslims could only find refuge in religion and in a Mosque (Ali et al., 2005). In addition, individuals did not have funds for psychological counselling (Ali et al., 2005). According to Ali et al., (2005), individuals were unsure of other safe places to get free help. Therefore, these Imams spent an excess of 1-10 hours a week, counselling members (Ali et al., 2005).

Within the South African context, Abdullah (2002), mentions the need for Imams to assist members of the Muslim community with counselling. The need for spiritual leaders to assist occurred during Apartheid when communities depended on faith to keep their morale high (Abdullah, 2002). Communities were unable to seek out mental health assistance, neither could they afford to if the opportunity arose (Abdullah, 2002). According to Davis (as cited in Abdullah, 2002, p. 74) Imams were "regarded as the leader and spiritual guide of the community and communal solidarity was secured through him".

Mental health and Islam within the South African context.

Laher and Ismail (2012) state that from a South African context, psychologists tend to use an integrated approach of psychology, religion and cultural backgrounds. This is a complex yet successful approach as every individual comes from a different cultural background that can be incorporated into psychological treatments (Laher & Ismail, 2012). Laher and Ismail (2012) found that individuals were more accepting of help with the use of this multifaceted approach. If individuals are aware that these integrated approaches exist, they would be more likely to seek out help and recommend help to others (Laher & Ismail, 2012). This would assist in decreasing the stigma surrounding mental health within the South African Muslim community (Laher & Ismail, 2012).

Ally and Laher (2008) reported that within the South African context if a faith healer was approached by individual to assist with mental health issues, they would help however they could and still recommend these individuals to seek out proper medical help as faith healers cannot provide feedback as a medical doctor or psychologist. Again, this assists the process of de-stigmatization of seeking psychological help (Ally & Laher, 2008).

Mohamed-Kaloo and Laher (2014) emphasize the importance of community awareness regarding mental illnesses with the intention to decrease stigma. Mohamed-Kaloo and Laher (2014, p. 352) also state that various community interventions and healthcare professional interventions need to be put in place in order to start a conversation of mental health such as "a collaboration between healthcare professionals, including traditional healers" and the development of community talks. Mohamed-Kaloo and Laher (2014) conclude that there is a need for more qualitative research that would provide the importance of the role of culture and religion in the understanding of mental health within the South African context.

The critique of mental health and Islam within the South African context is that there is inadequate research done on how South African middle-adult Muslims understand mental health. The strength of the research done by Ally & Laher (2008); Laher & Ismail (2012); Mohamed-Kaloo & Laher (2014), is that there are individuals at various levels in society such as faith healers and psychologists, that promote seeking professional psychological help. This will greatly assist with people understanding mental health better, the destigmatization of mental health and how individuals with mental disorders will be viewed.

Literature conclusion.

The aim of psychological intervention is the assistance in treating, realization of potential, helping individuals work through various traumas and even providing diagnosis if certain mental health issues are presented (Rothman & Al-Karam, 2018). There needs to be an overall sense of understanding of the aim of psychological treatments in order to decrease the stigma that comes with individuals seeking out these western approaches (Laher & Ismail, 2012). It needs to be understood that there are numerous ways to treat individuals and sometimes intervention outside of religion can be used or alternatively, religious or spiritual therapies can be used alongside western therapies to achieve affective interventions (Laher & Ismail, 2012). More research is needed to determine the processes by which these components can best be integrated and, on how South African middle-adult Muslim understand mental health. The overall goal of these efforts is to enhance the effectiveness of therapy, to enhance the lives of individuals who seek out therapy, destigmatize mental health and enhance how individuals understand mental health (Ally & Laher, 2008; Laher & Ismail, 2012; Mohamed-Kaloo & Laher, 2014).

Methodology

The methodology section includes an explanation of the chosen paradigm for the research, the constructivist paradigm, along with the various aspects surrounding the research

design. Thereafter, the population, unique characteristics of the population and the sample required for the research have been discussed. Next, the data collection method and data analysis method has been explained. Lastly, the trustworthiness of the research has been described.

Research Paradigm

Constructivist paradigm.

A constructivist paradigm was used since as it stated that there is no single truth or reality and therefore, society creates ideas and reality (Dewey, 1986). Constructivism is often referred to as a type of learning which is intensely subjective and a very personal process of people actively modifying the way in which they think (Dewey, 1986). According to Dewey (1986, p. 241), the founder of this paradigm, he states that "the necessity of the introduction of a new order of conceptions leading to new modes of practice". Whereas Bagnoli (2013, p. 1) referred to constructivism as a "metaphor of construction" by agents who conceptualise ideas and act them out.

Constructivism is a collective term for social constructivism, cognitive constructivism and radical constructivism (Dewey, 1986). Vygotsky is regarded as the pioneer of social constructivism based on his social learning theory as it understood that "psychological phenomena emerge from social interaction" (Liu & Chen, 2010, p. 64). Cognitive constructivism comes from the works of Piaget which states that individuals cannot be given information. Individuals construct their own knowledge based on information drawn from experiences and this causes them to create schemas- mental models of the world (Powell & Kalina, 2009). According to Woolfolk (as cited in Sample, 2002), Vygotsky offered an alternative to Piaget's work in cognitive development. Vygotsky focussed on how "students learn through social interactions and their culture" (Sample, 2002, para. 6).

The constructivist paradigm links to the research topic as views of mental health are constructed within the Muslim community and overlaps into the way people with mental disorders and treated and viewed. Perceptions are created by society and therefore, society should be questioned (Dewey, 1986). Dewey (1986) makes mention of society operating blindly until we expand on our knowledge of concepts and that extends itself into the research as its aim is to understand how mental health is viewed. Constructivism is constantly linked to learning as we often behave way in which we were taught to (Dewey, 1986). Therefore, Dewey's definition of constructivism will be used in this paper.

Ontology, epistemology and axiology in the constructivist paradigm.

Ontology within the constructivist paradigm suggest getting "answers to fundamental

and existential questions" (Flockhart, 2016, p. 5). Its ontology suggests social construction of the perception of mental health in Islam. Epistemology within the constructivist paradigm refers to learning that offers an explanation of the nature of knowledge and how human beings learn (Ültanir, 2012). This is often based on previous experience and background knowledge (Ültanir, 2012). Its epistemology suggests understanding and acknowledgement of mental health. Axiology within the constructivist paradigm focuses on ethics and meta-ethics as this paradigm tends to understand the nature, scope and meaning of moral judgement (Bagnoli, 2013). Therefore, axiology depends on the researcher being unbiased and objective to obtain accurate results (Bagnoli, 2013).

Research design

Qualitative research methods are generally oriented towards understanding meanings and lived experiences (Crowe, Inder & Porter, 2015). Therefore, a qualitative approach is useful in a mental health context (Crowe et al., 2015). Qualitative research assists in providing insight into poorly understood areas and complex concepts (Fossey et al., as cited in Crowe et al., 2015). For this reason, qualitative research methods are useful in this type of research as it is targeted at gauging what South African middle-adult Muslim men understand about mental health.

A cross-sectional analysis is an "empirical comparison may involve data derived from different contexts" (Crowe et al., 2015, p. 619). It is regarded as a snapshot of a given point in time (Crowe et al., 2015). A cross-sectional analysis was also used by Parveen, Sandilya & Shafiq (2014); Tay et al., (2019) when conducting their study on mental health. Therefore, a cross-sectional analysis is suitable for this study.

Deductive reasoning will be used as it has been used as it works in accordance with various aspects of the research such as the constructivist paradigm and the social cognitive theory (Rips,1994). In addition, Bandura's Social Cognitive Theory (1989, 2001, 2005) has already been applied to the research. The Social Cognitive Theory (Bandura, 1989, 2001, 2005) is a predeveloped theory that is used explain the social phenomena that is occurring. Therefore, this concept will be used in this research as there is a theory mentioned prior to the data collection (Rips,1994). Data will be analyzed, followed by incorporation of the Social Cognitive Theory which summarizes the data (Bandura, 2001; Rips, 1994).

Interactive approaches are used during conducting a qualitative questionnaire (Crowe et al., 2015). In this research, questions are static and standardized however, the researcher can be contacted to clarify questions (Crowe et al., 2015).

Population

For this research, the target population was Muslim men. To narrow this down, the target population adopted parameters (Pascoe, 2014). The population parameters were middle-adult men within Kwa-Zulu Natal. In addition, these men were required to be of the Muslim faith and practising Muslims. Middle-adult men were selected from all walks of life, irrespective of their occupation and marital status. The chosen population was appropriate as it aimed to answer the research question that focused on middle-aged adults and their views of mental health.

Unique characteristics of population.

Male (biological and gendered).

Seminal authors work Ally & Laher (2008); Laher & Ismail (2012); Laher et al., (2018); Mohamed-Kaloo & Laher (2014) often do not distinguish between genders when conducting their research. Therefore, this added angle of only males being used for the research would add onto already published works of Ally & Laher (2008); Laher & Ismail (2012); Laher et al., (2018); Mohamed-Kaloo & Laher (2014). In addition, hopefully this research could create other areas of research.

Middle-adult – 45-65 years old.

Again, seminal authors work of Ally & Laher (2008); Laher & Ismail (2012); Laher et al., (2018); Mohamed-Kaloo & Laher (2014), often do not have a narrower age range when conducting research. In addition, middle-adulthood is considered the stage of generativity versus stagnation (Erikson as cited in Slater, 2003).

Religious group – Islam.

Islam has its own view of mental health (Hankir et al., 2017; Ijaz et al., 2017); Rothman & Al-Karam, 2018; Sulaiman & Gabadeen, 2013). This is a result of various Islamic scriptures and Prophets (Hankir et al., 2017; Ijaz et al., 2017); Rothman & Al-Karam, 2018; Sulaiman & Gabadeen, 2013). The intersection of faith and psychology was vital to this research and was noted.

South African Citizen.

Studies conducted by seminal authors Ally & Laher (2008); Laher & Ismail (2012); Laher et al., (2018); Mohamed-Kaloo & Laher (2014) focus of psychology within South Africa, however, people are constantly evolving and this needs to be constantly documented.

Sampling

The units of analysis will comprise of the responses given by participants (Braun &

Clarke, 2006). Due to the COVID-19 pandemic and governmental laws of social distancing, participants were emailed qualitative questionnaires. Thereafter, participants responses were emailed back to the researcher and then compared (Braun & Clarke, 2006). A non-probability sampling method was deployed since there were specific unique characteristics which were required for the research (Maree & Pietersen, 2020). Snowball sampling is a technique used in non-probability sampling and was applied to collect data (Maree & Pietersen, 2020). This ensured that finding participants was done easily since one participant would be able recommend the next (Maree & Pietersen, 2020).

Initially, five participants were to be sent a qualitative questionnaire since a qualitative research method was going to be applied (Braun & Clarke, 2006; Maree & Pietersen, 2020). However, due to the difficulty in finding willing participants, only three participants were used for the study and purposive sampling was used as the researcher found all three participants.

Upon giving the participants the qualitative questionnaires, certain characteristics were found. Presently, participants A is a 47-year-old male, security business owner, father of three and is married for nine years. In addition, participant A is a practicing Muslim and did not have any history of mental health problems. However, participant A did have a prior partner who was diagnosed with Bipolar Disorder and was knowledgeable about mental health. Participant B is a 48-year-old male who owns an automobile-spare company, is a father of two, and is currently married for 25 years. Participant B is also a practicing Muslim. In addition, participant B has a child who has Attention Deficit Hyperactive Disorder (ADHD) and is well-informed on the behavioural disorder. Participant C is a 58-year-old maxillofacial oral surgeon, father of two, is a divorcée and a practicing Muslim. Participant C is a hafidth (Muslim male who has memorized the Qur'an). This also mean that participant C was educated about understanding the meaning of Quran. Currently, participant C is completing his PhD in dental surgery and due to his many years of studying, has extensive knowledge on mental health. Participant C was diagnosed with depression 15 years ago and is still taking medication for it.

Data Collection Method

Method.

A qualitative questionnaire is described as a data collection method which attempt to elicit more in-depth responses from participants (Kang et al., 2020). It is usually used in instances where reflective questions are asked (Kang et al., 2020). A qualitative questionnaire

fit into the type of data required to be collect and was appropriate due to the global pandemic, coronavirus (Kang et al., 2020). The work of Kang et al., (2020), a questionnaire was the safest approach to use.

Advantages.

Seminal authors work such as Ally & Laher (2008); Laher & Ismail (2012); Laher et al., (2018); Mohamed-Kaloo & Laher (2014) supported the use of open-ended questions. Open-ended questions often allow participants to go into further detail regarding their answers (Nieuwenhuis, 2020b). The strengths of open-ended questions are the ability to probe into the participants responses (Nieuwenhuis, 2020b). Participants were given additional space on the questionnaire to add much information that they could and this benefitted the overall analysis of data (Nieuwenhuis, 2020b). In addition, questions are standardized and this allowed for the easy comparison of responses (Nieuwenhuis, 2020b). From this, themes and concepts can be grouped together, which enhanced data analysis and results (Nieuwenhuis, 2020b).

Limitations.

The limitations of open-ended questions are analysing data becomes time consuming (Nieuwenhuis, 2020b). Excess data recorded can become redundant and unimportant (Nieuwenhuis, 2020b). It could be difficult to group data into similar concepts, themes or attitudes (Patten, 2016). Participants needed to be literate as they would be required to read the questions and fully comprehend what was being asked of them (Patten, 2016). Participants would also be required to verbally express themselves (Patten, 2016). Participants would also need to be educated on mental health.

Overcoming limitations.

It was important that the limitations be counteracted to achieve the best possible result for the research (Patten, 2016). To avoid questionnaire fatigue, only five questions were given to participants (Nieuwenhuis, 2020b). All questions were in the same order to ensure that data analysis was done with ease (Nieuwenhuis, 2020b). Researcher details were given to participants (Nieuwenhuis, 2020b). This allowed participants to contact the researcher for clarification on certain questions (if needed) (Fritz & Vandermause, 2017). Encrypted modes of communication were used such as encrypted emails (Fritz & Vandermause, 2017; Parker, 2008). This ensured safe and confidential communication (Fritz & Vandermause, 2017; Parker, 2008).

Collecting data.

The study required gatekeeping permission from the IIE Varsity College. Due to COVID-19, social distancing needed to occur and qualitative questionnaires were emailed to participants via encrypted emails (Kang et al., 2020; Parker, 2008). Email encryption ensured that no unauthorised personnel had access to the email and its contents (Parker, 2008). Participants were given seven days to complete the qualitative questionnaire and send it back to the researcher. *See annexure A for the qualitative questionnaire.*

Data analysis method

The purpose of data analysis was to compress the collected information to answer the research question, objectives and to draw conclusions from the findings (Braun & Clarke, 2006; 2012). Since this was a qualitative research study, a thematic analysis was used to analyse the data (Braun & Clarke, 2006; 2012). Thematic analysis is a type of analysis process that entailed identifying, analysing and explaining various themes or patterns that emerged within data (Braun & Clarke, 2006). Thematic analysis assisted with organising data by finding a repeated pattern of meanings (Braun & Clarke, 2006; 2012). It was useful for summarising key points from large amounts of data (Braun & Clarke, 2006; 2012). However, due to the flexibility of thematic analysis, it can result in inconsistent and incoherent themes (Braun & Clarke, 2006; 2012). Braun and Clarke (2006; 2012) stated that thematic analysis was used to identify similarities and differences in participants responses. Thus, forming a coherent understanding of how middle-adult Muslim men in South Africa view mental health. This was done by giving all participants received the same questionnaire. This allowed data to be easily compared by employing methods of coding, generating themes, naming themes and compiling a final report (Braun & Clarke, 2006; 2012). Another limitation of thematic analysis was that it was a broad analysis method which made it difficult to focus on one aspect. The reliability of thematic analysis was questioned as it is based on the researcher's interpretations of the data. In overcoming this, the researcher consulted with their supervisor to ensure that they were correct in their analysis method.

Application of data analysis method.

The data analysis process drew on the works of Braun and Clarke (2006; 2012). The data analysis process assisted with how to code, group, generate themes, and name themes (Braun & Clarke, 2006; 2012). The process will be discussed in six phases (Braun & Clarke, 2006; 2012).

Phase 1: Familiarising yourself with the data.

During this step, the data from the qualitative questionnaires were collected and read

over multiple times (Braun & Clarke, 2006; 2012). This ensured that data was understood and patterns could emerge for the next process of thematic analysis (Braun & Clarke, 2006; 2012). It was a time-consuming task however, it was needed to understand the data as well as become more familiar with the data (Braun & Clarke, 2006; 2012). For example, the researcher examined the question, "Given your understanding of mental health, how has this understanding influenced your interactions with individuals who may have a mental disorder?" while reading through the responses of all three participants to become more familiar with it (Braun & Clarke, 2006; 2012).

Phase 2: Generating initial codes.

After carefully reading through the participant's completed questionnaires, the researcher found that codes could be created from each answer (Braun & Clarke, 2006; 2012). Codes are a part of the data that seems meaningful and interesting to the researcher (Braun & Clarke, 2006; 2012). This allowed the main points from each answer to be extracted (Braun & Clarke, 2006; 2012). During this phase, the researcher worked on a computer and underlined meaningful excerpts from the participants answered qualitative questionnaires. Each excerpt was assigned a code (Braun & Clarke, 2006; 2012). Each transcript was then placed into a table which contained the underlined text and the code (Braun & Clarke, 2006; 2012). After coding all the transcripts, a list of the assigned codes was placed in a sperate document (Braun & Clarke, 2006; 2012). Based on the example given in phase 1, the researcher coded that participants were sympathetic to individuals with mental disorders and encouraged people to seek therapy.

Phase 3: Searching for themes.

Codes such as life challenges, mental health dismissed, importance of education, regression, increase awareness, increase acknowledgment, and remove stigma were some of the code that were found in the data. These codes along with many others, were reviewed and similarities emerged (Braun & Clarke, 2006; 2012). Another table (on a separate document) was created where similar codes were grouped together (Braun & Clarke, 2006; 2012). These codes merged into themes (Braun & Clarke, 2006; 2012). Three possible themes emerged (Braun & Clarke, 2006; 2012). It was found that possible theme could be, awareness of mental health in the Muslim community, the influence of Islam on mental health and stigmatization of mental health.

Phase 4: Reviewing potential themes.

Once all themes were created, they were reviewed to determine whether they overlapped or could be further broken down (Braun & Clarke, 2006; 2012). Furthermore,

themes were reviewed to determine whether they were valid and linked to the researched literature, objectives and research question (Braun & Clarke, 2006; 2012). Once this was completed, there was a clear idea of what themes emerged from the codes and what they revealed about the data gathered from participants (Braun & Clarke, 2006; 2012). During this phase it was found that themes such as awareness of mental health in the Muslim community, the influence of Islam on mental health and stigmatization of mental health arose from the data and were extremely relevant to the research question, researched literature and objectives. These themes were further reviewed in relation to each other and the dataset (Braun & Clarke, 2006; 2012).

Phase 5: Defining and naming themes.

This phase involved identifying the essence of each theme (Braun & Clarke, 2006; 2012). Again, themes were reviewed and each theme presented a topic of analysis that contributed to the final result of the research (Braun & Clarke, 2006; 2012). During this phase, themes were clearly defined, named and refined (Braun & Clarke, 2006; 2012). For example, the researcher found that some of the stigmatization of mental health existed within the Muslim community and the factors that contributed to this tension.

Phase 6: Producing the report.

The final phase comprised of writing up a report which reflects the essence of the data that was collected, coded, and themed (Braun & Clarke, 2006; 2012). The final report included direct quotes related to specific themes, the reviewed literature, and the research question. This process was aimed at reporting how mental health is viewed amongst South African middle-adult Muslim males.

Trustworthiness

Trustworthiness is extremely important in qualitative research when discussing reliability and validity (Nieuwenhuis, 2020a). Therefore, procedures that can be used for assessing the trustworthiness of data analysis, should always be closely observed (Nieuwenhuis, 2020a). According to Guba (as cited in Nieuwenhuis, 2020a) there are four criteria's that should be considered while pursuing qualitative research.

Credibility deals with the congruence of the research and findings (Nieuwenhuis, 2020a). A well-established research method, research design, and a research question need to be aligned with the research question and research methods (Nieuwenhuis, 2020a). This was displayed through questionnaires being answered by three participants who fitted the criteria of being a middle-adult South African Muslim male.

Transferability implied that the study can be applied to other contexts or environments (Nieuwenhuis, 2020a). This means that the research can be transferred to various settings (Nieuwenhuis, 2020a). The research is aimed at transcribing and understanding the understandings of mental health viewed by middle adult Muslim males. The study can also be transferred to various age groups within the religion and the study can be done amongst females too.

Dependability was used in preference to reliability (Nieuwenhuis, 2020a). Dependability is demonstrated through the research design and the manner in which it is implemented (Nieuwenhuis, 2020a). This includes areas of research such as data-gathering and methodology (Nieuwenhuis, 2020a). Dependability can be viewed in this research through the standardized and static questionnaire that was given to all participants. The study can be standardized and repeated with the use participants with various characteristics by using the same questionnaire. Notes were taken throughout the research which can be given to other researchers to repeat the research within various contexts.

Confirmability is described as the degree of neutrality or the extent to which the findings of a study are shaped by the participants and not by researcher bias, motivations or subjective views (Nieuwenhuis, 2020a). A process critical to this is known as an audit trail which allows any observer to trace the course of the research through each step so there is complete transparency about the decisions taken and procedures adhered to (Nieuwenhuis, 2020a). Another valuable support to data interpretation was the use of direct quotes that could indirectly support an argument which can display researcher bias (Nieuwenhuis, 2020a). To demonstrate confirmability transcripts of participants will be readily available to view in order to adhere to transparency in the research conducted.

Interpretation and Presentation of Findings

The interpretation and presentation of findings section includes the results and discussion of these results. Thereafter, the themes found from the qualitative questionnaires have been explored.

Results and Discussion

The research study was aimed at understanding how mental health is viewed amongst South African middle-adult Muslim males. Three middle-adult men were sent questionnaires pertaining to mental health and the Muslim experience of mental health. These qualitative questionnaires had five questions. All participants received the same questions.

Three themes emerged namely: awareness of mental health in the Muslim community, the

influence of Islam on mental health and stigmatization of mental health. Each theme clearly links back to the overall research question, but each theme is distinct (Braun & Clarke, 2006). Each theme is explored and supported by literature reviewed.

Theme 1: Awareness of mental health in the Muslim community.

A theme of awareness arose from the data collected. Participants had mentioned that mental health was a concept that was not mentioned in Muslim community. In addition, another participant mentioned that it was something they tried to create awareness within their household.

For example, when asked if mental health is discussed in the Muslim community. Participants A stated,

"No, I guess the old school parents never gave it much thought"

This is supported by the findings of Keshavarzi and Haque (2013, p. 233) as they mention that older generations and Muslims who are typically from Islamic states made attributions towards demonic possession referred to as "Djin" as causal explanations for poor mental health. Other typical causes of ill mental health included being cursed or "separation from the divine" (Keshavarzi & Haque, 2013, p. 233). In Muslim societies disorders are recognized distinctively in relation to religion (Ahmad & El-Jabali, 2015). For instance, disorders like depression or anxiety are commonly perceived as a deficiency in faith, or attributed to the lack of prayer (Ahmad & El-Jabali, 2015). On the other hand, conditions such as bipolar disorder or schizophrenia is associated with demonic possession (Ahmad & El-Jabali, 2015). That being said, one can infer that in Muslim societies, mental illness is associated with negative and non-medical perceptions (Ahmad & El-Jabali, 2015). Mental health due to chemical imbalances (in the brain) was generally not considered by older generations (Weatherhead & Daiches, 2010).

In addition, the participants response was supported by the work of Bandura (2005) who stated that individuals' observations affect behaviour by modelling. Participants did not find the need to further peruse their knowledge of mental health as it was not mentioned in their homes by older generations (such as parents). The social cognitive theory states that individuals tend to model the behaviour of those who they identify with (Bandura, 2005). Participants modelled the behaviours of those in their community and household (Bandura, 2001). Psychological and social components in one's lives influence behaviours, ideas and even the construction of one's reality (Bandura, 2001).

According to El-Islam (2015, p. 2), religion helped older generations provide a meaning for stress and its "evaluation according to religious cognitive schemas". Religion instilled hope

in the belief that through God, stressors and other obstacles would remove themselves through continuous prayer (El-Islam, 2015; Sulaiman & Gabadeen, 2013).

Similarly, participant B states mental health is a concept that is

> *"…discussed and sometimes dismissed"*

This is supported by the works of Laher et al., (2018) who stated the association between culture and mental illnesses. Laher et al., (2018) mention culture often hinders individuals from acknowledging and understanding mental health as a chemical imbalance in the brain and not a concept brought upon by lack of faith. However, Laher et al., (2018) mentions that culture should be included in developing effective treatment and interventions.

Participant B mentions that mental health was a concept that was only brought up in their home due to having personal experience with an Attention Deficit Hyperactive Disorder (ADHD) child. ADHD is a common childhood behavioural disorder that can persist into adulthood (Sayal, Prasad, Daley, Ford & Coghill, 2018). ADHD symptoms include limited attention and hyperactivity and can result in decreased self-esteem (Sayal et al., 2018). Treatment of ADHD includes talk therapy and medication (Sayal et al., 2018). This allowed the conversation to begin within his household and be further discussed.

> *"…like ADHD is known only to those parents that have been through a rigorous process, where other parents believe their child is just naughty and does not look for the help"*

This is further supported by the works of Laher et al., (2018) said where the Muslim community do not seek out western forms of treatment to further help their children or other family members. Again, there is reinforcement of the belief that bad behaviour or ill health is due to supernatural forces to due to spiritual illness (Laher et al., 2018). However, Keshavarzi and Haque (2013, p. 231) mention the centrality of religious practice in the lives Muslims "renders the outcome for any psychological treatment a function of the degree to which the intervention is skillfully applied within the context of the religion". Hankir et al., (2017) mention that the stigma attached to mental health is the reason why members of the Muslim community do not speak about their aliments or attempt to seek out help.

Theme 2: Influence of Islam on mental health.

A theme of the influence that Islam and has on mental health arose from the data collected. For example, participant B stated

> *"Islam teaches us about humanity and one cannot understand humanity or humility if they don't have a good mental health."*

This is supported by the works of Laher et al., (2018) as the mention encouraging others to seek out help. Islam teaches people to help others if you have the means to (Ciftci et al., 2013; Laher et al., 2018). Sabry and Vohra (2013, p. 205) state that "Islam provides Muslims with a code of "behaviour, ethics, and social values, which helps them in tolerating and developing adaptive coping strategies to deal with stressful life events". It is also important to develop a strong social support system in the process of bettering your mental health (Jackson & Erving, 2020; Laher & Ismail, 2012). This in turn would assist in decreasing the social stigma that surrounds mental health within the Muslim community (Laher et al., 2018). Ciftci et al., (2013) mention that through this continued process of destigmatization, there will be less alienation of individuals with mental disorders. All of these endeavours should help in destigmatizing the taboo surrounding mental illnesses and allow more people in the future to come forward and get proper treatment (Ahmad & El-Jabali, 2015). Ahmad and El-Jabali (2015) go on to mention that those suffering from mental illness should be afforded the same dignity and respect as those with physical ailments.

Conversely, participant C stated,

> *"Islam does not influence my understanding of mental health because I am aware of the complex biochemical and neurological processes involved and what the impaired and unbalanced functions can result but I am more comfortable with Muslim therapist…"*

This is supported by the work of Rothman and Al-Karam (2018) as they mentioned that different psychological approaches must be used to treat different populations, even within the same religion. Rothman and Al-Karam (2018) stated that for orthodox Muslim clients, Islamic psychology approaches can be used whereas for more westernised Muslims, a Muslim psychological approach can be used. Muslim psychology is an approach used by Muslim therapists for Muslim clients (Rothman & Al-Karam, 2018). However, treatment practices are not rooted in religion (Rothman & Al-Karam, 2018). Muslim psychology focuses on how Muslims behave and think (Rothman & Al-Karam, 2018). A Muslim psychological approach is useful as, "allows for psychotherapy to be more relevant to Muslim populations and to perhaps make such services palatable where they may otherwise be

stigmatized as ‘Western,’ ‘secular’, ‘un-Islamic’, or simply not culturally relevant” (Rothman & Al-Karam, 2018, p. 26). Muslim clients tend to be more open to receiving therapy if their therapist is more likely to understand their religious or cultural view (Rothman & Al-Karam, 2018). Similarly, Hamdan (2008) states religious understanding in conjunction with Western psychological treatments can be used to provide structure to therapeutic interventions and can assist clients with personal growth.

Theme 3: Stigmatization of mental health.

A theme of the stigmatization of mental health in the Muslim community emerged from the data collected. For example, participant A stated,

> *“I’m very neutral on the matter with a get “to know” your mental health status with the all members of a family/unit and seek professional help. Not stigmatize the person and claim they are insane.”*

And,

> *“Islamic institutions marketing their knowledge and support of all mental health issues to all people such as where to get help…”*

This is supported by the works of Ahmad and El-Jabali (2015) as they mentioned facing stigmatization within the Muslim community. Ahmed and El-Jabali (2015, p. 2) go onto state that the “underlying cause of this stigma, in many cases, can be attributed to simple ignorance and lack of understanding the illness itself”. As a result of this stigmatization, individuals suffering from mental disorders, such as depression and anxiety, are unable to approach their family or community members for support (Mohamed-Kaloo & Laher, 2014; Rothman & Al-Karam, 2018; Skinner, 2010). This makes it difficult for them to get the medical attention they require (Mohamed-Kaloo & Laher, 2014; Rothman & Al-Karam, 2018; Skinner, 2010).

The continuous loop of stigmatization of mentally ill individuals can be seen through the social cognitive theory where people model behaviours of others and treat mentally ill individuals negatively (Ahmad & El-Jabali; 2015; Bandura, 2005). Therefore, Ahmad & El-Jabali (2015); Ally & Laher (2008), mention that it imperative that community members and especially local Muslim community leaders, such as Imams, create an open dialogue about mental health and make an effort in understanding what mental health is. This will enable community members suffering from depression or anxiety to seek help and support from them (Imam) (Ahmad & El-Jabali; 2015; Ally & Laher, 2008). In addition, if the Muslim

community notices that religious leaders are enabling a nonstigmatizing and non-judgmental approach, the community will model this behaviour (Ahmad & El-Jabali; 2015; Ally & Laher, 2008; Bandura, 2005).

Ahmad and El-Jabali (2015, p. 4) state that "that mental illness, just like physical illness, requires medical treatment and cannot be overcome by faith and prayers". Faith does help soothe aliments but it will not treat the underlying pathology (Ahmad & El-Jabali, 2015; Ally & Laher, 2008). Hence, Imams should be capable of understanding the indications that may point to mental problems expressed by individuals, thus encouraging these individuals to seek the opinion of a medical expert (Ahmad & El-Jabali; 2015; Ally & Laher, 2008).

Conclusion

The conclusion section includes an explanation of how the results were linked to the research question and objectives. To follow, the implication of the research's findings was discussed. Thereafter, the ethical implications of the research were explored. Lastly, the limitations of the research were unpacked.

Linking to the research question and objectives

The research question that was stated in the research was "What do South African Muslim middle-adult males understand about mental health?". In addition, the objectives of this experience were to explore the understanding of mental health from a South African middle-adult Muslim males' perspective, to explore how Islam has contributed to the understanding of mental health and to explore the incorporation of psychology (mental health) and Islam. From the findings, one can conclude that the participants have an understanding about what mental health is but also, they are aware of the stigma that surrounds mental health. In addition, the participants are aware that Islam has an impact on how they view mental health. However, from their perspective, Islam encourages individuals to seek knowledge and get help for their mental health. It is also important to note that participants encouraged others to seek western forms of psychological treatment but also incorporate religious remedies to ensure a speedier and wholesome recovery. Furthermore, it was identified that participants stated that having a Muslim therapist assisted in having an effective therapy. There has been a change in perception and understanding of mental health within the Muslim community. However, there is still stigma that exists with individuals within the Muslim community. There must be a continuous open dialogue about mental health so the Muslim community is educated, stigma decreases and the overall understanding of mental health is a more clear, concise and definitive definition.

Implication of findings

Upon consulting the research conducted by Ally & Laher (2008); Laher & Ismail (2012); Laher et al., (2018); Mohamed-Kaloo & Laher (2014), it was apparent that more research needed to be done in this field. An untouched area of research was discovered. The niche of this research focuses on the South African middle-adult Muslim males understanding. Ahmad & El-Jabali (2015); El-Islam (2015); Keshavarzi & Haque (2013) have done extensive research on the Muslim experience within Saudi Arabia. Hankir et al., (2017) researched on the Muslim experience in Ireland. Ijaz et al., (2017) conducted research in Pakistan. Several of these studies did not indicate the gender of their sample and age. This made the need for the research more apparent. Upon reviewing research, it was decided that research should focus on South African middle-adult Muslim males.

The research on middle-adult Muslim males view of mental health aims to contribute to the field of Social Psychology. In addition, it attempts to add to the existing body of knowledge thus, contributing to previous studies conducted on mental health within the Muslim community. Furthermore, it can provide a South African perspective on how mental health is viewed in the Muslim community. Due to the qualitative nature of the research, it could allow for more detailed quantitative research in the future as the quantitative data could be more useful when making a comparison between two variables. Furthermore, the research aims to gain a deeper understanding how mental health is viewed in the Muslim community and how middle-adult South

Ethical implications

No psychological harm was inflicted during this research process as it was received ethical clearance. Participants were given various forms to fill in which explained the research, informed them of the research process and were given a consent form (Nieuwenhuis, 2020b; Stanley & Guido, 1996). *See Annexure B and Annexure C.* Participants were provided information that deals "explicitly with matters of data storage and analysis, anonymity and 'participant monitoring' to check responses and send reminders" (Parker, 2008, p. 81). There was also a checklist for the researcher which ensured that rules and regulations were adhered to and research supervisors were aware of various factors of the research (Parker, 2008; Stanley & Guido, 1996).

All participation was and will be kept private and confidential (Parker, 2008; Stanley & Guido, 1996). Participation was voluntary, and the participants could withdraw from the research process at any point (Parker, 2008). Participants details were kept private (Parker,

2008; Stanley & Guido, 1996). Participants responses were and still are confidential (Parker, 2008; Stanley & Guido, 1996). Responses will not be given to any unauthorized parties (Parker, 2008; Stanley & Guido, 1996). Participants real names were replaced throughout the research to ensure that confidentiality and anonymity was maintained (Parker, 2008; Stanley & Guido, 1996). Data protection issues were of particular importance when using email (Parker, 2008). Emails were encrypted to ensure no unauthorised personnel had access to their information (Parker, 2008). The participants were reassured of the safekeeping of their data during the research study (Parker, 2008; Stanley & Guido, 1996). Participants data was destroyed after use (Parker, 2008; Stanley & Guido, 1996). This is in keeping with IIE Varsity College Westville's policy.

The Health Professions Council of South Africa (n.d.) states that researchers must comply with the legal framework. Adhering to the South African constitution was key as the research must not and did not harm participants in any way (HPCSA, n.d.). The role and responsibility of the researcher was read and understood, but most importantly, adhered to (HPCSA, n.d.). The researcher implemented their disciplines ethical practices and fundamental ethical principles (HPCSA, n.d.).

Limitations

A possible limitation of this study was that it was conducted with amongst all races (Jackson & Erving, 2020). Race affects the way individuals understand aspects (Jackson & Erving, 2020). Therefore, race was an unaccounted impact of the understanding of mental health in Islam. However, this research does not negate the understandings of mental health with across all races.

Another limitation of the research was the small scale of the research. Research was conducted by obtaining data from three participants. An interesting take on the research could be qualitative research that included more participants to give a more accurate generalized assumption of how South African middle-adult Muslim males view mental health.

Islam is a major factor of the research being conducted. A possible limitation could be the research being conducted by a Muslim female who is approaching Muslim males. According to Metcalf (1984), since there is an intersection of sciences and religion being asked, the topic requires certain *adab* (respectable behaviours) when being addressed. This was vital as respect or *adab* is extremely important in Islam. (Metcalf, 1984). Respect was shown through addressing the participants politely and not interacting with the participants during prayer times (Metcalf, 1984)

A present-day limitation of the study was demonstrated through the data collection method. Due to COVID-19 various, governmental restrictions occurred which limited interactions and travel (Kang et al., 2020). The research could have been more data rich if face-to-face interviews had taken place. Questions could have been asked and answered immediately as opposed to emailing a qualitative questionnaire with a participant and waiting several days for a response.

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Annexures

Annexure A - Questionnaire

Please fill in the following details

NAME	
CELL NO	
EMAIL	
AGE	

Instructions

Please answer the questions below with as much detail as possible. Please note that you have three days to answer the following question.

1- What is your understanding of mental health?

2-Is mental health awareness discussed in the Muslim community? If yes or no, please state why.

3-How has Islam influenced your view on mental health? Provide a detailed description of how this has occurred.

4- Given your understanding of mental health, how has this understanding influenced your interactions with individuals who may have a mental disorder?

5- What opportunities would you like to have to improve your awareness of mental health?

If you know of anyone who would be suitable for this research, please provide their details below

NAME	
CELL NO	
EMAIL	

Annexure B – Explanatory Form

EXPLANATORY INFORMATION SHEET

Explanatory Information Sheet

To whom it may concern,

My name is Tahiyya Razak and I am a student at IIE Varsity College Westville. I am currently conducting research under the supervision of Lucinda Johns about A qualitative study understanding how mental health is viewed amongst South African middle-adult Muslim males. I hope that this research will enhance our understanding of how middle-adult South African Muslim males understand mental health.

I would like to invite you to participate in my study. In order to explain to you what your participation in my study will involve, I have formulated questions that I will try to fully answer so that you can make an informed decision about whether or not to participate. If you have any additional questions that you feel are not addressed or explained in this information sheet, please do not hesitate to ask me for more information. Once you have read and understood all the information contained in this sheet and are willing to participate, please complete and sign the consent form below.

What will I be doing if I participate in your study?
I would like to invite you to participate in this research because you fit the required criteria. If you decide to participate in this research, I would like to provide me with your full name, age, and answer a questionnaire.

You can decide whether or not to participate in this research. If you decide to participate, you can choose to withdraw at any time or to decide not to answer particular interview questions.

Are there any risks/ or discomforts involved in participating in this study?
Whether or not you decide to participate in this research, there will be no negative impact on you. There are no direct risks or benefits to you if you participate in this study. You might, however, indirectly find that it is helpful to talk about your understanding of mental health. If you find at any stage that you are not comfortable with the line of questioning, you may withdraw or refrain from participating.

Do I have to participate in the study?

- Your inclusion in this study is completely voluntary;
- If you do not wish to participate in this study, you have every right not to do so;
- Even if you agree to participate in this study, you may withdraw at any time without having to provide an explanation for your decision.

Will my identity be protected?
I promise to protect your identity. I will not use your name in any research summaries to come out of this research and I will also make sure that any other details are disguised so that nobody will be able to identify you. Nobody else, including anybody at IIE Varsity College, will have access to your interview information. I would like to use quotes when I discuss the findings of the research, but I will not use any recognisable information in these quotes that can be linked to you.

What will happen to the information that participants provide?

Once I have finished all interviews, I will write summaries to be included in my research report, which is a requirement to complete my BA Honours in General psychology. You may ask me to send you a summary of the research if you are interested in the final outcome of the study.

What happens if I have more questions about the study?

Please feel free to contact me or my supervisor should you have any questions or concerns about this research, or if there is anything you need to know before you decide whether or not to participate.

You should not agree to participate unless you are completely comfortable with the procedures followed.

My contact details are as follows:
Tahiyya Razak
[redacted]

The contact details of my supervisor are as follows:
Lucinda Johns
[redacted]

Annexure C – Consent Form

CONSENT FORM

Consent form for participants	
I, _____, agree to participate in the research conducted by Tahiyya Razak about A qualitative study understanding how mental health is viewed amongst South African middle-adult Muslim males. This research has been explained to me and I understand what participation in this research will involve. I understand that: • I agree to be interviewed for this research. • My confidentiality will be ensured. My name and personal details will be kept private. • My participation in this research is voluntary and I have the right to withdraw from the research at any time. There will be no repercussions should I choose to withdraw from the research. • I may choose not to answer any of the questions that are asked during the research interview. • I may be quoted directly when the research is published, but my identity will be protected.	
Signature	**Date**

Annexure D – Concept Table

Research Purpose/ Objective	Primary Research Question	Research Rationale	Seminal Authors/ Sources	Literature Review – Conceptual Framework	Paradigm	Approach	Data Collection Method(s)	Ethics	Anticipated Findings	References
The purpose is to understand what South African Muslim middle-adult males understand about mental health.	What do South African Muslim middle-adult males understand about mental health?	People in the Muslim community have various perceptions of mental health Some people avoid treatment or after talking to their partners or parents or siblings, are told that they simply lack faith Some people require therapy, counselling and even medication	Ally & Laher, 2008; Laher & Ismail, 2012; Mohamed-Kaloo & Laher, 2014; Laher, Bemath & Subjee, 2018	**Theme 1:** Awareness in Muslim community **Theme 2:** Influence of Islam on mental health	**Paradigm** Constructivist **Epistemology** Understanding and acknowledgement of mental health **Ontology** social construction of the perception of mental health in Islam **Axiology** unbiased and objective	Qualitative **Population** *Age*-40-65 *Religious group*-Islam *Gender*-Male South african	Structured, open-ended. Qualitative questionnaires	-consent forms will be filled out -participants can choose to withdraw at anytime -participants can choose to be anonymous -participants can view the final research should they choose to -confidentiality is vital	I would hope that the participants have a well-rounded and balanced view of mental health.	Ally, Y., & Laher, S. (2008) Braun, V., & Clarke, V. (2014) Ciftci, A., Jones, N., & Corrigan, P. W. (2013) El-Islam, M. F. (2015) Ijaz, S., Khalily, M. T., & Ahmad, I. (2017) Islam, F., & Campbell, R. A. (2014) Laher, S., Bemath, N , & Subjee, S. (2018) Laher, S., & Ismail, A. (2012)
Research Problem	**Secondary Questions/ Hypotheses/ Objectives**	**Key Concepts**	**Key Theories**			**Sampling**	**Data Analysis Method(s)**	**Limitations**	**Anticipated Contribution**	
The integration of psychological assistance in treating mental health in the Muslim community	*-explore the understanding of mental health from a South African middle-adult Muslim males' perspective -To explore how Islam has contributed to the understanding of mental health -To explore the incorporation of psychology (mental health) and Islam.*	-mental health -mental health in Islam -middle-adult	social cognitive theory (SCT)			Non-probability snowball **Size:** 3	**Unit of Analysis** Participants responses **Data Analysis Method(s)** Thematic analysis	-race -a woman interviewing men -finding participants, respect -religion being a sensitive topic -small scale research. -Covid-19, social distancing	Doing the research from a South African perspective with a middle-adult male population.	

Student na
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Re: Approval of Psychology Honours Proposal and Ethics Clearance

HONOURS ETHICAL CLEARANCE LETTER

Your research proposal and the ethical implications of your proposed research topic were reviewed by your supervisor and the campus research panel, a subcommittee of The Independent Institute of Education's Research and Postgraduate Studies Committee.

Your research proposal posed no significant ethical concerns and your supporting documents and instruments are in order to proceed. We hereby provide you with permission to proceed with your research.

In the event of you deciding to change your research methodology in any way, kindly consult your supervisor to ensure all ethical considerations are adhered to and pose no risk to any participant or party involved. A revised ethical clearance letter will be issued.

We wish you all the best with your research!

GENERAL CONDITIONS TO BE FULFILLED IN RELATION TO RESEARCH

Permission is granted to proceed with the above study subject to the conditions listed below being met and may be withdrawn should any of these conditions be flouted.

Please note: The panel has not considered the merits, accuracy or ethical soundness of the research. The only merits examined are the use of The IIE as a sample.

Permission is granted subject to the following conditions:

1. The researcher(s) will need to obtain informed consent in writing from all of the participants in his/ her sample if the study is not anonymous.

THE INDEPENDENT INSTITUTE OF EDUCATION

3. Photographs of
informed
photo
4. Th

should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.

5. No names or identifying information of participants may be used within the research and the research must be voluntary.
6. Please make it clear that the information will not be used punitively in any way and participants may in no way be counselled/advised based on this.

[redacted]

Lucinda Johns

[redacted]

Campus Postgraduate Coordinator
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