The impact of Islam and Muslim identity on experiences and views of mental ill health among Muslim men in south Wales.

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DECLARATION
This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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STATEMENT 1
This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used the extent and nature of the correction is clearly marked in a footnote(s). Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Abstract

This work answers the research question: “What is the impact of Islam and Muslim identity on experiences of mental ill health among Muslim men in south Wales?”. It conducted interviews with 21 Muslim men living in south Wales around their views and experiences of mental health, in relation to their gender and religion. Mental health is a topic of increasing conversation in the U.K., and religious and culturally appropriate care and support is something that many services are aiming towards. This study concluded that the intersectional elements of Muslim men, such as their ethnic backgrounds or age, impact their views and experiences of mental ill health. These views and experiences are additionally affected by their believed ideas of masculinity, stemming from both religion and culture. It explores the relationship between religion and culture and how this may impact other factors. It also explores the barriers many Muslim men experience when trying to seek support for mental ill health.

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This whole process has been extremely special. I was the first person in my family to attend University. My mum left school at 16 and my dad moved here from Libya in search of an education which never happened. I hope I have made both of them proud.

As someone with ongoing lived experience of mental ill health, this PhD has been partly an introspective journey, and I wanted to ensure I did the best for my participants who courageously shared their stories with me. I cannot thank them enough for their participation and for the hopeful positive change their accounts will make to Muslim mental health services. I hope I have done you all justice.

Over the last seven years, much of my academic, voluntary, and job careers to Muslim mental health. It is something that has been incredibly close to my heart, and I feel as though this study is a somewhat of a culmination.

I jokingly wrote in an earlier draft that I would like to thank caffeine for its help. Though, as any PhD student will know, caffeine is essential to the process. So, thank you Redbull, Monster, and Sainsburys' Pink Bolt. (Other energy drinks are available).

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CHAPTER ONE: INTRODUCTION

This thesis answers the research question: "What is the impact of Islam and Muslim identity on experiences of mental ill health among Muslim men in South Wales?". To explore this question, I conducted an in-depth literature review of the relevant subject material, followed by running a series of interviews with Muslim men in South Wales. Subsequently, the interviews were analysed, with the key themes chosen for further investigation. These themes were discussed in relation to contemporary ideas in the fields of Muslim mental health and masculinity. This work sits at the intersection of Sociology, Psychology, and

Islamic Studies. This thesis offers significant insights into Muslim men's mental health and can and should be used to inform future policy and practice within the field. The working assumption held prior to my beginning fieldwork is that Islam, and cultural backgrounds have a high impact on experiences and views of mental ill health amongst Muslim men in south Wales.

This thesis also deliberates on themes of masculinity, and how this, coupled with an individual's religious, cultural, and geographical (namely, living or growing up in Wales) backgrounds, may have shaped their views and experiences of mental ill health. I wanted to observe these factors in their own right and pay special attention to how religious and cultural backgrounds could both intertwine and be separated in participants' daily lives. In this thesis, I examine how participants interpret both religion and culture, and where their cultural expectations sit within their ideas of Islamic expectations and the Muslim man ideal.

From broad research and experience in the Muslim mental health field, I noticed that there existed a substantial research gap regarding the study of Muslim men's mental health which focused on faith in addition to ethnic background. Furthermore, what research touched on this topic tended to make ethnicity the main focus point of the research, as well as conflate religion and ethnicity. This present study contributes to filling this research gap through acknowledging religion and ethnicity as two distinct, separate, yet sometimes ambiguous, categories. It is the first study of mental health amongst Muslim men in south Wales, in addition to a mental health study which encompasses the individuals' intersectional backgrounds.

The study of mental health in general has always been of interest to me, particularly in relation to faith as a potential protective factor. The relationship between faith, mental health, and culture is one which has been explored and debated in many contexts, but this thesis is the first to examine the context of Muslim men's mental health in South Wales.

Having worked, researched, and volunteered in mental health for some years prior to and during this PhD, I understand the importance of this work on a practical as well as academic level. Mental health has been a much-discussed topic of conversation in public life, especially as a result of the COVID-19 pandemic. Though the COVID-19 pandemic was unexpected at this work's inception, it was important to engage with this subject because the

effects and aftereffects of the pandemic itself, in addition to the lockdown restrictions during 2020 and 2021, inevitably affected individuals' mental health.

Before proceeding, it is imperative to discuss the meaning of terms which will be used in this thesis which may cause contention or confusion for the reader in order to provide clarity. In this instance, the similarities and differences between the terms 'religion' and 'spirituality'. 'Religion' and 'spirituality' are terms which are often conflated and used interchangeably. Koenig et al., differentiated religion and spirituality through two criteria. Firstly, that religion requires rituals or prescriptive behaviours. Secondly, that religion may "involve a search for nonsacred [sic] goals either in or outside a religious setting".[1] These non-sacred goals may include actions such as going to religious services for non-religious goals, for example making friends. Koenig et al., use these definitions of religion and spirituality.

"Religion: Religion is an organised system of beliefs, practices, rituals and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community.

Spirituality: Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community".[2]

It is these definitions of religion and spirituality that this thesis uses in order to define each concept. Overall, religion tends to be more organised, and can be distinguished by established traditions, constructed to enable the worshipper to get closer to the divine. Conversely, spirituality is more mystical and less structured. Though there exists an overlap, I would argue that religion cannot exist without spirituality, but spirituality may exist without the ideas and rituals of religion.

[1] Harold G. Koenig, Michael McCullough, and David B. Larson, *Handbook of Religion and Health* (New York: Oxford University Press, 2001), 17.
[2] Ibid, 18.

Vaillant et al's study of religious involvement, mental health and physical health of men in the USA found a "significant" correlation between involvement in religion with 'stressful life events and depression'.[3] The latter which they noted are linked with "poor mental health".[4] They also found that though psychiatric visits to hospital and involvement in religion were linked to "stressful life events and depression", they were not linked with each other. We can infer from this that either those who are experiencing stress turn to religion for comfort and ease, or that religion causes stress. This questionable causality is further explored in the interviews for this thesis. An interesting and irregular finding from this study was that Valliant et al did not find that religious involvement increased with age in their participants.[5] One drawback of this study however is that it does not specifically focus on Muslim men, rather men from varying religious and spiritual backgrounds. This study however looks at whether the religious involvement of Muslim men affects overarching experiences of mental health.

The reason for choosing to study Muslims in Wales, and more specifically, south Wales was twofold. Firstly, the boundaries of my scholarship were limited to studying Muslims in south Wales. This thesis was generously funded by KESS 2, thus, the geographical constraints for this work were restricted to south Wales. This meant the development of this thesis was focused from its inception and allowed for an early concentration on existing literature. Secondly, and most importantly, studying Muslim men in south Wales and their mental health was a subject that had not yet been covered. Therefore, by conducting this research, I fill a large research gap and also make a novel and interesting contribution to the field. If acknowledged by policymakers and professionals, this study could have a profound positive impact on the field. As will be covered within this thesis, Muslims in Wales have a unique history, with the community itself being regarded as different from other large Muslim communities in cities across the U.K.[6] Within this thesis, I have sought to use statistics and information referring explicitly to south Wales. Where this was not possible, I used that pertaining to Wales, then England and Wales, and also those from the U.K as a whole.

[3] George Vaillant et al., "The Natural History of Male Mental Health: Health and Religious Involvement," *Social Science & Medicine (1982)* 66, no. 2 (January 2008): 221–31, https://doi.org/10.1016/j.socscimed.2007.09.011. 226.
[4] Ibid.
[5] Ibid, 227.
[6] Sophie Gilliat-Ray and Jody Mellor, "Bilād Al-Welsh (Land of the Welsh): Muslims in Cardiff, South Wales: Past, Present and Future," *The Muslim World 100*, no. 4 (2010): 452–75, https://doi.org/10.1111/j.1478-1913.2010.01331. 452.

For the purposes of this thesis, I am exploring the role of religion, specifically adherents to Islam. Within this work, I am paying less attention to spiritual beliefs, even though they may be associated to Islam. This is because I want to also examine the impact of the community aspect of organised religion on an individual's mental health. In this instance, for Muslim men's mental health, it includes the impact of attending the mosque and living within a Muslim community. For recruitment, I crafted the call for participants who identified as Muslim men, and though participants had varying levels of self-identified practice, they all considered themselves Muslims and adherents of Islam.

Within this thesis, I acknowledge the importance of both religion and culture on participants' lived experiences. Religion and culture are often conflated by followers and researchers into religion. This is particularly the case with Islam, whose Arab roots are taken as canon culture; often ignoring the various cultures that contribute to modern day Islam. For example, a 2008 study by Bhui et al discussed a Pakistani woman who kept religious prayers in a Taveez, a kind of amulet, and used it for protection.[7] Though it did contain religious texts, the concept of using items such as amulets for protection are not rooted in the Qur'an and Hadith but more so in Muslim cultures. However, for those who utilise such practices, they regard them as a legitimate part of Islam and their religion. This merging of religion and culture will also be examined in the later part of this section in relation to djinn and the evil eye. The methodology section will also explore this notion further, examining religion and culture through interviews and the pre-interview questionnaire.

This thesis concentrates on Muslim men; therefore, it must acknowledge gender disparities within mental health, in addition to theories surrounding the study of masculinities. Men can often exhibit symptoms and experience mental health differently to women and it is therefore important to understand the different contexts. It is a topic for which there has been little research conducted, but a narrative to which this thesis will make a worthwhile contribution. There is yet to be a specific study conducted on Welsh Muslim men's mental health, making this thesis the first of its kind; but also, one which has the validity to be able to be applied more widely to British Muslim men's mental health. Later in the thesis, theorists of masculinity are discussed in relation to this study.

[7] Simon Dein and Kamaldeep Singh Bhui, "At the Crossroads of Anthropology and Epidemiology: Current Research in Cultural Psychiatry in the UK," *Transcultural Psychiatry* 50, no. 6 (December 1, 2013): 769–91, https://doi.org/10.1177/1363461513498618. 147.

Outline of Literature Review

In order to best illustrate and examine this research, this thesis is split into the subsequent five chapters. The Literature Review introduces the topic of mental health in the general sense, then examines the gap in the literature which this thesis seeks to fill, as well as the limitations of this study. It then broadly discusses religion and spirituality, and their relationship to mental health, and the research which has already been conducted into religious communities with specific respect to mental health. Following this, mental health in the U.K. is examined more broadly; and then discusses the focal group of this study, Muslims in south Wales and the Welsh Muslim community. Afterwards, it looks at literature regarding possible causes and symptoms of mental ill health in relation to Muslims and Muslim men, including stigma, trauma, and Islamophobia. The section ends with a delve into Muslim men and the role of gender, mental health, and illness as a consequence of the COVID-19 pandemic. The topics of the Literature Review were chosen as the most pertinent themes relevant to this study, through the utilisation of Grounded Theory, as explained in the Methodology section. As there are no resources on Muslim men's mental health in south Wales already, it was appropriate to examine wider mental health studies in the U.K, as well as Muslim mental health, and men's mental health in order to accumulate necessary data and resources.

Outline of Methodology

Then, the thesis moves to the Methodology chapter, overviewing the methods used to obtain data from participants. I provide an analysis of my chosen theoretical frameworks, covering Grounded Theory and my epistemological choice of Durkheim's theory of functionalism. This chapter deliberates on my theoretical and epistemological choices, and why other choices, such as approaches taken by theorists Weber and Marx were not appropriate in this instance. I then progress to covering interviews, why I chose that method for obtaining qualitative data, and how COVID-19 impacted my research methods. It then takes an in-depth look at the participants, how they were gathered, and any notable impacts. Lastly, this chapter takes reflects on myself as a researcher and how this dynamic may have affected this

research; acknowledging and addressing not only any biases that I may have, but also any experiences which may have positively impacted this research.

Outline of the Data Chapter

Next, the Data chapter considers the interviews themselves in relation to the data in the Literature Review; observing whether any of the key points from that section mirror what was found during the interviews. This chapter also discusses the organisation of the qualitative data and how the information was sorted into themes. It details notable quotes from the interviews, examining differences and similarities in reference to participants demographics, such as age or ethnicity. This section also deals with the thesis's epistemological concerns, notably discussing the impact of Durkheim and his ideas of religion and functionalism, and how they can be applied to this topic. Included within this discussion are the changing narratives around mental health that exist within the British Muslim community, and how conversations are becoming steadily more positive, and more people feel they are able to seek help for any mental health issues.

Outline of Discussion Chapter

The Discussion chapter reviews the participants' relationship between religion and mental health; examining whether individuals find comfort in their faith, and the means by which they achieve this outcome. It looks at the links between ethnicity and culture and their views on mental health. It discusses themes such as stigma, suicide, djinn, and how the participants view those factors. This also provides an overview of the theories of masculinity, through which the data sets could be analysed. The discussion chapter discusses these findings in relation to theories of masculinity and ends by providing detail of the scope for further research based on this thesis. This work also provides recommendations for practitioners and those working within the field of Muslim mental health in order to help better engage with, and support, Muslim men.

Outline of Conclusion Chapter

This thesis ends with a conclusion which summarises the key arguments made, in addition to providing an overview of what was covered in each of the chapters as well as key themes

of this work. It also discusses the impact of this research on the wider fields of the study of Religion, Mental Health, and Masculinity. Discussions of current events and how they may be directly impacting Muslim men's mental health are included in this section as well.

Throughout this thesis, verses from the Qur'an are used to emphasise points or provide justification for views and arguments. This thesis utilises the Qur'an translation by MAS Abdel Haleem, as it is a recognised text which provides an accessible translation for laity.[8] Where individual translations may need to be used, I utilise the Hans Wehr and Edward W. Lane dictionaries in addition to the Qur'an Corpus tool by the Language Research Group at the University of Leeds.[9] Furthermore, it uses transliterations where appropriate from Brill's transliteration guide for academics.[10] From my previous study of the Arabic language, these tools were recommended when translating the Qur'an. This method of translating and transliteration was chosen in part as they are widely used amongst academics, in addition to its simplicity of language used and the explanations it provides.

[8] M. A. Abdel Haleem, *The Qur'an* (New York: Oxford University Press, 2005).
[9] "The Quranic Arabic Corpus - Word by Word Grammar, Syntax and Morphology of the Holy Quran," accessed March 7, 2020, https://corpus.quran.com/.
[10] Pim Rietbroek, "Brill's Simple Arabic Transliteration System," 2010.

CHAPTER TWO: LITERATURE REVIEW

This chapter introduces core themes discussing the impact of Muslim identity on Muslim men's mental health in South Wales. It begins with an overview of the broader topics of mental health, and the relationship of mental health within a religious context. It then delves deeper into the specific situations of the mental health of men; specifically, the mental health of Muslim men and examines whether satisfactory research exists. I argue that though there has been some initial headway in recent years within the field, there are major gaps in the literature which this thesis seeks to fill. Muslims in the UK are usually seen as an ethnically homogenous entity, so gaps exist when discussing cultural and racial intricacies within the community. This thesis examines the relationship between individuals' background and their views on mental health, creating a discourse on intersectionality within this topic. Similarly, there exists a lack of research on Muslim men's mental health in general. This chapter also suggests the justification for, and limitations to, pursuing this line of inquiry; with a reflexive consideration for the needs and pitfalls of this research topic, particularly considering present day influences such as Islamophobia and COVID-19.

Conversations around mental health and mental illness are growing, especially in light of the COVID-19 pandemic.[11] Statistics show that it is an issue from which increasing numbers of people are seeking mental health support.[12] This thesis focuses on the social and religious implications of mental health and mental illness and how they impact Muslim men at both an individual and community level. My findings are later used to inform recommendations for communities on how to support Muslim men with mental health issues.

This chapter concentrates the existing literature on five key themes. It discusses mental health in a wider context to understand why there is an increasing need for research in the field. It moves to discuss how religion and spirituality may relate to mental health. Then, this chapter provides information on the literature surrounding men's mental health, and how their gender could impact it. It then focuses on the Welsh Muslim context, and why south

[11] "How COVID-19 Changed the Conversation on Mental Health," Optum, accessed December 5, 2023, https://www.optum.com/health-articles/article/healthy-mind/how-covid-19-changed-conversation-mental-health/.
[12] "Rising Demand for Mental Health Care - Care Quality Commission," CQC, accessed December 5, 2023, https://www.cqc.org.uk/publications/major-reports/soc202021_01d_mh-care-demand.

Wales in particular provides a unique scope for this work to be carried out. Lastly, as this thesis was completed during and after the COVID-19 pandemic, this chapter discusses how this once-in-a-generation event impacted the mental health of Muslims in Britain.

Though research into mental ill health has increased in recent years, there still exists many areas yet to be studied. It also discusses the remit of this study and acknowledges that there are research gaps unable to be filled by this present work. This thesis lies firmly within the sociological studies of Religion, and at the intersection of Sociology, Mental Health and Religious Studies.

To contextualise this study, it is needed to acknowledge the population of Muslims within the U.K., and more specifically, Wales. According to the Muslim Council of Britain Census report (2015) following the 2011 national census, Muslims make up almost 5% of the population of England and Wales.[13] This population is growing, and the number of Muslims in England and Wales has increased from the 2001 census. There are just under 46,000 Muslims in Wales alone, with the majority of these concentrated in Cardiff and surrounding cities in south Wales.[14] Comparatively, the 2021 census results state that Muslims in the UK make up 6.5% of the population of England and Wales.[15] The Muslim population of Wales amounted to 67,000 people, which is an increase of 1.5% from the 2011 census.[16]

Mental Health

It is important to discuss mental health in its wider context to draw comparisons to be drawn between specific issues or illnesses within the Muslim community, and in the general community more broadly. However, due to a lack of data documenting religion, it is difficult to obtain comparative statistics between the two sets. It is a subject which, notably, has been

[13] Sundas Ali and Muslim Council of Britain, eds., *British Muslims in Numbers: A Demographic, Socio-Economic and Health Profile of Muslims in Britain Drawing on the 2011 Census* (London: Muslim Council of Britain, 2015), 22.
[14] Ibid, 25
[15] "Religion, England and Wales - Office for National Statistics," ONS, accessed November 29, 2023, https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/bulletins/religionenglandandwales/census2021
[16] "Ethnic Group, National Identity, Language and Religion in Wales (Census 2021)," GOV.WALES, November 29, 2022, https://www.gov.wales/ethnic-group-national-identity-language-and-religion-wales-census-2021-html.

gaining importance throughout recent years with more and more charities and organisations expanding their focuses and commitments to mental health and mental illness. This chapter provides definitions for commonly used terms in the Mental Health field as well current ideas on social understandings of mental health.

This thesis will use terms such as "mental health", "mental illness", and "mental ill health". It is important to define these terms and describe the context in which they are used, as they are often conflated and used interchangeably. Individuals may often use the broader term "mental health" to describe the more specific "mental illnesses". It is important to define them here, in order to provide clarity for this thesis. During interviews, I was able to garner from context, whether a participant was perhaps using one term when meaning to use another. Mental health influences how an individual thinks and feels about themselves, and how they may interpret an event. Self-esteem and self-worth can all contribute to mental health and mental wellbeing. Mental health can affect coping ability as well as the capacity to receive information and handle stressors.[17] When one is equipped with positive mental health, free of illness, they are able to cope with the day-to-day normal stressors of life; and are able to be productive and contribute to their communities.[18] These definitions, stemming from the World Health Organisation, and adopted by Public Health Wales, will be used throughout this work to give clarity to what is meant by 'mental health'. Though these are general definitions of mental health conditions, others, such as those who suffer from High-Functioning Depression, may not fit these criteria exactly. It is a general sentiment amongst, particularly mental health organisations, that mental health exists on a spectrum or continuum.[19] This has mental wellness (good mental health) on one end, and emotional distress (poor mental health) on the other.[20] One may move along the spectrum throughout the day, month, or week. Mental ill health is when that wellbeing is less positive, and mental illness is a diagnosed condition with which one may live.

[17] Dr Lynne Friedli, "Mental Health, Resilience and Inequalities," *World Health Organisation Europe (*2009), https://psychrights.org/countries/WHO/who2009.pdf. 64; Silvana Galderisi et al., "Toward a New Definition of Mental Health," *World Psychiatry* 14, no. 2 (June 2015): 231–33, https://doi.org/10.1002/wps.20231. 231.
[18] "Mental Health: Strengthening Our Response," World Health Organisation, accessed February 9, 2021, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.
[19] "Understanding the Spectrum of Mental Health," Take Action for Mental Health, accessed 26 January 2024, https://takeaction4mh.com/resources/understanding-the-spectrum-of-mental-health/.
[20] "Information for 11-18 Year Olds on Understanding Mental Health," MIND, accessed 26 January 2024, https://www.mind.org.uk/for-young-people/introduction-to-mental-health/understanding-mental-health/.

Mental ill health can impact everyday life for sufferers. According to the U.K. charity the Mental Health Foundation (MHF), those living with mental health problems are some of the least likely of those suffering from long-term health conditions to "find work, be in a steady, long-term relationship, live in decent housing [and] be socially included in mainstream society".[21] MHF notes that this is due to outdated and stereotypical views of mental illness. For example, the perception that those who suffer with these kinds of conditions are violent, dangerous, or likely to harm others. This sentiment is more common with less understood conditions and symptoms, such as Schizophrenia and post-partum mental illness. Further, MHF confirms that socioeconomic factors such as lack of housing, employment, and finances are all connected to mental ill health, and can become a cycle which is hard to break. This has also been reflected in the Welsh population with high rates of positive wellbeing being reported by individuals who were employed versus those who were not. Lower rates of positive wellbeing were also found among those who lived in rented accommodation, suggesting that housing instability could contribute to poorer mental health.[22] It is important to consider the multitude of sources of mental illness such as financial concerns or other socioeconomic issues. While this was not explicitly covered within interviews, many participants spoke of financial pressures being an issue for their mental health.

Gap in the literature

The literature covered in this chapter details the existing knowledge on the topic of Muslim men's mental health, however, there do exist many gaps requiring further research, which is where this thesis adds to the field. This section will provide an overview of the gaps in the literature relating to mental health amongst Muslim men, for this thesis to situate itself within the relevant fields. This thesis sits at an intersection between Sociology, Islamic Studies, Gender Studies, and Mental Health. This study is sociological in nature but contributes to a gap which exists in all the aforementioned fields.

[21] "Stigma and Discrimination," Mental Health Foundation, last modified August 7, 2015, https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination.
[22] Public Health Wales Observatory, "Public Health Wales Observatory - Mental Wellbeing in Wales (2020)," (Public Health Wales Observatory), accessed April 9, 2020, http://www.publichealthwalesobservatory.wales.nhs.uk/mental-wellbeing-2020.

Ciftci et al, noted the need for "further research" in the fields relating to Mental Health and Muslim communities, with respect to gender, race and ethnicity, and intersectionality, saying that these topics have gone "largely unexplored".[23] By concentrating on Muslim men and their cultural and ethnic backgrounds, this thesis is able to give a nuanced view of mental health from this standpoint. As this thesis somewhat explores the intersectionality between religion, race/ethnicity, and gender, it is important to briefly provide a background in this. One prominent theorist in race studies is Crenshaw, who founded Critical Race Theory, and coined the term 'intersectionality'. Crenshaw used the term intersectionality initially to refer to the experiences of Black women and their "interaction between race and gender."[24] This thesis examines the effect of participants' intersectional identities on their views and experiences of mental ill health. Crenshaw acknowledged that intersectionality "only highlights the need to account for multiple grounds of identity when considering how the social world is constructed."[25] Therefore, I am considering intersectional identities within this work.

Altalib et al.'s 2019 study which included fifteen years of analysis of Muslim mental health research from around the world, discusses that the research into mental health and culture is just that: studying culture, ethnicity, and race but not religion.[26] They argue that due to the increasing Muslim population, and the traumas this population experiences, there is a need for more specific, extensive studies which look at religion as a whole. This thesis seeks to substantially discuss the impact of religion on mental health, whilst simultaneously taking into consideration each participant's cultural and ethnic background. Thus, providing a comprehensive overview and separating religion from culture and ethnicity.

Gearing and Alonzo's study also stated that works which looked at some psychological disorders such as "depression, anxiety, obsessive compulsion, neuroticism, pessimism and death obsession" found that the cases were higher in majority Muslim countries than those

[23] Ayse; Jones Ciftci, "Mental Health Stigma in the Muslim Community," *Journal of Muslim Mental Health* 7, no. 1 (2012): 102, https://doi.org/10.3998/jmmh.10381607.0007.
[24] Kimberle Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *The University of Chicago Legal Forum 1989,* no. 8 (1989): 1. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8. 140.
[25] Kimberle Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color', *Stanford Law Review* 43, no. 6 (1991): 1241–99, https://doi.org/10.2307/1229039. 1245.
[26] H. H. Altalib et al., "Mapping Global Muslim Mental Health Research: Analysis of Trends in the English Literature from 2000 to 2015," *Global Mental Health* 6 (May 16, 2019): 3. https://doi.org/10.1017/gmh.2019.3. 1.

in Western samples.[27] Though it does not specify whether or not Muslims in non-majority Muslim countries were sampled in these instances, we can infer that due to the comparison made, that they were not. This is something that will be further explored, regarding thoughts and experiences of different mental health conditions. Furthermore, it is explored whether views and experiences of suicide are different from those of some of the psychological disorders listed above. Within their study, Gearing and Alonzo found that overall, male individuals with less religious belief are associated with an increased suicide risk, though this was not identified in females.[28] In this instance, religious beliefs were measured with quantifiers such as fasting during Ramadan or adherence to the daily prayers. They acknowledge the "potential protective impact of religious affiliation and commitment against suicide", and especially as it relates to men. [29] In practice, it is important for Islamic leaders to have a holistic understanding of mental wellbeing and mental illness as many of their congregation may seek support through Muslim leaders. This is further covered within the Data and Discussion chapters of this thesis. A study by Biermann notes that an understudied area in religion and mental health is the buffering effect; "the role of religion in protecting against the negative effects of stressors on mental health".[30] Some examples include whether or not religion would protect or improve issues such as socioeconomic difficulty or unemployment levels and may contribute to poorer levels of mental wellbeing.

Gearing and Alonzo succinctly sum up the importance of this thesis in saying that "future research is needed to more fully understand the unique protective role that Islam provides against suicide across the wide range of practicing individuals".[31] The thesis looks at whether Muslim men in south Wales view their adherence to Islamic beliefs, as a risk or protective factor of mental ill health.

Eryilmaz and Kula's *Investigation of Islamic Well-Being and Mental Health* determined that most studies which examine the relationship between Islam and mental health have addressed this topic theoretically but that there is a need for the area to be covered

[27] Robin Edward Gearing and Dana Alonzo, 'Religion and Suicide: New Findings', *Journal of Religion and Health* 57, no. 6 (1 December 2018): 2478–99, https://doi.org/10.1007/s10943-018-0629-8. 2489.
[28] Ibid, 2480
[29] Ibid, 2479
[30] Alex Bierman, "Does Religion Buffer the Effects of Discrimination on Mental Health? Differing Effects by Race," *Journal for the Scientific Study of Religion* 45, no. 4 (2006): 551–65, http://www.jstor.org/stable/4621935. 552.
[31] Gearing and Alonzo, "Religion and Suicide," 2490.

empirically.[32] This thesis uses experiences and interviews, in addition to textual analysis and theoretical concerns to examine the relationship between Muslims, Islam, and Mental Health. Therefore, this verifiable experience can further support arguments made.

Dein and Bhui's examination into cultural psychiatry in the UK found that there was a lack of research on religious coping and how ethnic minorities may use religion to cope with stresses.[33] This study provides analysis into how the Muslim men in south Wales interviewed use religion as a positive or negative coping mechanism. Bobat, who conducted a study on User-Led Mosque research, found that his participants felt that when they were unwell, remembering Allah and attending the mosque helped them to be able to cope with their illnesses.[34]

Tarabi, in his study demonstrating the underutilisation of mental health services amongst Pakistani Muslim men in the UK, noted that research on the issue was lacking in two main areas. Firstly, that most studies focused on Muslims, especially South Asians, as a culturally homogenous group without taking into consideration the diversity existing through culture and ethnicity.[35] Secondly, he notes that the majority of research focused on the views and experiences of South Asian women, with little consideration being given to men.[36] This thesis seeks to fill both gaps mentioned by Tarabi through ensuring cultural and ethnic diversity is examined, and by concentrating the study on the views and experiences of Muslim men. Tarabi also says there has been a lack of consideration towards second-generation Pakistani Muslim men. Within this thesis, participants are asked about their ethnic backgrounds and whether they are first, second, or third generation immigrants to draw conclusions on the impact this may have on an individual's mental health. They are also asked about adherence to a particular school of thought within Islam to determine whether this affected their relationship with mental health and mental illness.

[32] Ali Eryilmaz and Naci Kula, "An Investigation of Islamic Well-Being and Mental Health," *Journal of Religion and Health* 59, no. 2 (April 2020): 1096–1114, https://doi.org/10.1007/s10943-018-0588-0. 1114.
[33] Dein and Bhui, "At the Crossroads of Anthropology and Epidemiology," *Transcultural Psychiatry*, 50(6), (December 2013): 768-791, doi: 10.1177/1363461513498618, 783.
[34] Hanif Bobat, "A User-Led Research Project into Mosque" (The Mental Health Foundation), accessed May 5, 2020, https://www.mentalhealth.org.uk/sites/default/files/user-led-research-mosque.pdf, 8.
[35] Said Aris Tarabi "Exploring the Experience of Second Generation Pakistani Muslim Men in Individual CBT," (PhD diss., London Metropolitan University, 2016), https://repository.londonmet.ac.uk/1220/1/TarabiSaidAris%20-%20DProf%20Full%20Thesis.pdf, 16.
[36] Ibid

This section has shown where this thesis fits within the wider literature. As shown, this thesis fits into many gaps, covering not only the basic questions surrounding Muslim men and mental health, but also further questions around culture and ethnicity.

Limitations of the Study

There are some limitations to this study in regard to how it fills a research gap and how it fits within a wider context. The limitations regarding this study's methodology process, and the data collected, are discussed in later sections of this thesis.

While this study does indeed fill much needed gaps, there are confines. This study does not provide a textual analysis of Qur'an, Hadith, or other religious texts. While these sources are not unimportant to understanding the relationships between religion and mental health, an exhaustive study of these texts would not necessarily be a priority into understanding current trends and attitudes of mental health among Muslim men in south Wales. This thesis provides a generic overview of the standpoints of Islam with mental health, and participants were free to discuss any textual ideas or quotes that they may have found important to their own mental health.

As this work is not a psychological study, it only provides a brief overview of the views and research of psychologists as, for the purposes of this sociological study, it is outside of the remit. I do not have experience in psychology, and to turn this into a psychological study would be a disservice to both fields. Though they may be useful in determining the views held by current therapists, counsellors, and psychologists, this thesis does not interview these professionals or seek to understand specific medical or psychological methods which they use to treat those suffering. The focus of this study is one of a sociological nature.

Religion and Spirituality

This section will explore the literature on mental health and religion. As there is not a great wealth of literature on specifically Muslim men and mental health, it is important to have an overview of the subtopics that make up aspects of the research questions. The definitions of

religion and spirituality were covered in the Introduction section of this thesis. Much of the literature on religion and mental health is varied in its approach. Though many find comfort in their faith, some studies suggest it could potentially worsen mental health. Some aspects of religion such as forgiveness or compassion can help those suffering with mental ill health by giving them a source of comfort. On the other hand, some behaviours present in religious rituals – such as *wudu*, the ablutions made before Islamic prayers- could be triggering for those who present with obsessive or compulsive behaviours.[37] These ideas will be further examined within this section of the Literature Review.

Research in Religious Communities

Overall, the research into mental health and religion has been predominantly concentrated on Judaism and Christianity, with little regard for Islam despite it being the world's second largest religion. This may be because I am examining mental health and religion in Western countries, namely England and Wales, which were traditionally largely Christian. The 2021 census showed that in England and Wales, less than half of those surveyed identified themselves as Christian (46.2%) and No Religion (37.2%) was the second most common response to the religion question.[38]

There are a few fundamental and current pioneering works covering the topic of Mental Health and Religion, the most prominent of which is Koenig's *Handbook of Religion and Health* which was published in 2001. While this serves as an almost authoritative text for this field, for the specialism of Islam/Muslims and mental health, it does have its limitations. This book provides a comprehensive overview of religion and mental health in particular, though its title would lead one to believe it was for health overall. However, it scarcely covers Islam and mental health, mainly focusing on the Judeo-Christian traditions. It does allow for a broad understanding on the history of religion and mental health covering works by Freud and Jung and scriptural analysis of the Bible.

[37] "International OCD Foundation | Islam and OCD," *International OCD Foundation* (blog), accessed February 25, 2023, https://iocdf.org/faith-ocd/living-with-ocd-religious-traditions/islam-and-ocd/.
[38] "Religion, England and Wales - Office for National Statistics," accessed February 24, 2023, https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/bulletins/religionenglandandwales/census2021.

While there are some similarities between the three Abrahamic faiths (Christianity, Judaism, and Islam), the conclusions drawn by Koenig can not necessarily be taken as the same in the Islamic context. Many central rituals, although sharing similar levels of importance, are carried out differently in the faiths, such as prayer. Islam is specific in detailing how one should pray, how often, and commanding a ritual state of purity for the process. Similarly, in modern vernacular, it has become an increasing occurrence, especially in the UK, as a Christian nation (meaning that the component countries of the UK each have Christianity as the main religion) for individuals to simply refer to themselves as *culturally* Jewish or Christian, but without necessarily partaking in rituals. For example, one may celebrate Hanukkah or Christmas but not keep the Sabbath or the Lent fasts. For Muslims in the UK, it is much less common to come across these cultural approaches. Therefore, the relationships between the followers of Judaism, Christianity and Islam may be very different, and it cannot be a 'one-size-fits-all' approach to all religions and mental health.

Both in Europe and the United States, social scientists and psychiatrists looking at the relationship between religion and mental health have concentrated on Judaism and Christianity. Therefore, the intricacies of Islam and mental health especially in the U.K. have been largely overlooked, though it is a subject which has gained traction in recent years.

In 2017, Koenig and Al Shohaib made an attempt to add to the literature on mental health and Islam. Their book *Islam and Mental Health: Beliefs, Research and Applications*, provides a brief overview of Islam and mental health, focusing mainly on what evidence there is in the Qur'an and Hadith to support ideas around mental health.[39] At under one hundred pages long, it reads more like a pamphlet than an in-depth discussion. Where it does discuss modern day issues around mental health, it focuses on Muslims in the Arab World; and when discussing Muslims in the West, it concentrates on the USA. For the purposes of my study, while it is interesting to note some comparisons with the USA, as they are both Western, English-speaking countries, the makeup of the Muslim community in the UK is vastly different, so any generalisations would be difficult to apply to the British context.

Due to the interviewees in this study coming from various cultural and ethnic backgrounds, it is important to understand the perceptions of mental health from the relevant countries.

[39] Harold G. Koenig and Saaed Saleh Al Shohaib, *Islam and Mental Health: Beliefs, Research and Applications* (Duke University, 2017).

Additionally, practitioners should understand the thoughts of mental illness by individuals from different backgrounds in order to more effectively cater their treatments, provide improved, specialised support, and increase the general uptake of mental health services. A study by Donnelly et al discusses the perceptions of mental illness, specifically depression, in the Middle East and Arab World, finding that many believed that mental illness was caused by evil spirits and/or a divine punishment from God.[40] This study was specifically carried out in Qatar, a country where the majority of the population is Muslim. From this, we can assume that similar views are held by Muslims living in other parts of the region, specifically the Khaleej. This concept will be explored in the next section, specifically looking at mental health in the Muslim community. A 2011 study by Khalifa et al, found that the majority of the 111 U.K. Muslims who were interviewed believed in supernatural causes of mental illness, often *sehr* and djinn possession.[41] Over 50% of interviewees in the aforementioned study believed that treatment should come from both imams and medical professionals simultaneously. This figure is encouraging, showing that Muslims are open to a multi-faceted approach to mental illness.

Djinn and Exorcism

Djinns are a factor which occurs often within discussions of Muslim mental health. Although they are a legitimate and believed occurrence in the Islamic faith, their role is often exacerbated and used to explain mental ill health and mental illness. These ideas were seen in the interviews to be culturally prevalent. In Islam, Muslims believe in angels and djinn which live in different, but coexisting worlds to humans on Earth. The Qur'an and Hadith mention djinn often, and according to the Qur'an, much like their human counterparts, djinn can do good or evil.[42] In Chapter 15, Verse 27 of the Qur'an, it defines djinn as being created "from the fire of scorching wind".[43] According to Brill's Encyclopaedia of Islam, djinn (sometimes written as "jinn"), are "bodies composed of vapour or flame, intelligent, imperceptible to our senses, capable of appearing under different forms and of carrying out

[40] Tam Truong Donnelly et al., "Arab Men and Women's Conceptualization of Mental Health and Depression: A Qualitative Study from the Middle East," *Journal of Immigrant and Minority Health* 21, no. 5 (October 1, 2019): 1102–14, https://doi.org/10.1007/s10903-018-0809-3. 1103
[41] *Sehr* is defined as Magic, usually referring to black magic.; Najat Khalifa et al., "Beliefs about Jinn, Black Magic and the Evil Eye among Muslims: Age, Gender and First Language Influences," *International Journal of Culture and Mental Health* 4, no. 1 (June 1, 2011): 68–77, https://doi.org/10.1080/17542863.2010.503051.
[42] M. A. Abdel Haleem, ed., *The Qur'an*, Oxford World's Classics (New York: Oxford University Press, 2005). 107.
[43] Abdel Haleem, *The Qur'an,* 163.

heavy labours".[44] They also existed in Arabia pre-Islam and were not unlike nymphs or satyrs in Greek mythology.[45] Though djinn are similar to humans in some ways, they differ in how they originated. Chapter 15, verses 26-27 of the Qur'an says:

"We created man out of dried clay formed from dark mud -
the djinn We created before, from the fire of scorching wind".[46]

According to scholar Ali Olomi, djinn interact with humans through various means, coming under the categories of "visitations, influence, possession, marriage [and] abduction".[47] For the purposes of this thesis, it is the 'possession' aspect which is important. That is because, according to some Muslims, mental illness is seen as to be caused by djinn possession, rather than seen as a legitimate illness equating in seriousness physical illness.[48] As belief in what a djinn is/is not capable of can often stem from cultural, as well as religious views, this thesis may be able to make correlations between beliefs in djinn, cultural background, and view of mental illness. Though there is debate in the capabilities of djinn, what we can say is that djinn are part of the Islamic narrative. However, they are often used as the main causality for mental illness, shifting responsibility away from community help and intervention to a "being" on which one can impart blame.

A study by Khalifa, Hardie, and Mullick at the Royal College of Psychiatrists examines the differences of opinion in djinn between Muslim Bangladeshis in Dhaka with those in Leicester with surprising results. Compared with Muslims in Dhaka, British Muslims in Leicester were "more likely to believe in Jinn; less likely to believe in Jinn possession; more likely to believe that Jinn could cause mental health difficulties; more likely to cite religious figures as the treating authority for disease attributed to Jinn affliction; less likely to advocate treatment by doctors; and more likely to advocate joint working between doctors and religious leaders.", though they were less likely overall to believe in djinn possession.[49] From

[44] D. B. MacDonald et al., "Djinn," *Encyclopaedia of Islam, Second Edition*, April 24, 2012, https://referenceworks.brillonline.com/entries/encyclopaedia-of-islam-2/djinn-COM_0191?s.num=0&s.rows=20&s.f.s2_parent=s.f.book.encyclopaedia-of-islam-2&s.q=jinn.
[45] Ibid.
[46] Abdel Haleem, *The Qur'an*. 163.
[47] "Ali A Olomi on Twitter," *Twitter*, accessed February 9, 2021, https://twitter.com/aaolomi/status/1189612162584666112.
[48] Anastasia Lim et al., "The Attribution of Mental Health Problems to Jinn: An Explorative Study in a Transcultural Psychiatric Outpatient Clinic," *Frontiers in Psychiatry* 9 (March 28, 2018), https://doi.org/10.3389/fpsyt.2018.00089, 2.
[49] Najat Khalifa, Tim Hardie, and Mohammad S. I. Mullick, "Jinn and Psychiatry: Comparison of Beliefs among Muslims in Dhaka and Leicester" (Royal College of Psychiatrists, 2012), https://www.rcpsych.ac.uk/docs/default-source/members/sigs/spirituality-spsig/spirituality-special-interest-

this, we can infer that in the case of this ethnic group in particular, they are less likely to seek help with mental health difficulties from a medical professional alone, and more likely to feel that a religious figure is more appropriate to deal with djinn, and therefore mental illness, than a doctor. This response may perhaps then lead to individuals suffering worsened symptoms and a reluctance to encourage the treatment and prevention of mental illness through secular means.

Interference by djinn may include customs such as the evil eye (also often referred to as *nazar* or *ayn)*. The evil eye is generally seen as glances of envy from one person to another that can cause intentional or unintentional misfortune in the life of the envied. *Waswasa* can literally be translated as 'whispers', in the Qur'an used with examples of Satan whispering evil to humankind, such as in Chapter 20, Verse 120 where Satan whispered to Adam, but also in Chapter 50 verse 16 where Allah says,

"We created man – We know what his soul whispers to him: We are closer to him than his jugular vein".[50]

Al-Balkhi defined *waswasa* as "obsessions", perhaps more related to modern day notions such as Scrupulosity or Religious Obsessive-Compulsive Disorder (OCD). Other modern-day researchers refer to "*waswas al-qahri*", translated as "overwhelming whispers", and use this term to refer to a presentation of OCD.[51] From this, we can assume that whatever the origin of the *waswasa*, they can cause obsessions and sufferers may then use religious compulsions (such as praying a certain number of times) to try and rid themselves of them.[52] In modern texts, Koenig also discusses the prevalence of obsessive religious rituals. He says that "the obsessive-compulsive may pray or perform detailed, time-consuming religious rituals over and over again to relieve intolerable anxiety or guilt".[53] This emphasises the potential negative effects of religion. It is important for religious leaders to understand that for those who suffer from scrupulosity may find their symptoms worsening if religious

group-publications-jinn-and-psychiatry-comparison-of-beliefs-najat-khalifa-tim-hardie-mohammad-s-i-mullick.pdf?sfvrsn=5f13bcbb_2#:~:text=Muslims%20in%20Leicester%20(as%20compared,to%20advocate%20treatment%20by%20doctors%3B, 5.

[50] Abdel Haleem, *The Qur'an*. 340.

[51] "Clinicians, Imams, and the Whisperings of Satan," Yaqeen Institute for Islamic Research, accessed October 30, 2023, https://yaqeeninstitute.org/read/paper/clinicians-imams-and-the-whisperings-of-satan.

[52] Abū Zayd al-Balkhī and Malik Badri, *Abu Zayd AlBalkhi's Sustenance of the Soul*, The Cognitive Behavior Therapy of A Ninth Century Physican (International Institute of Islamic Thought, 2013), https://doi.org/10.2307/j.ctvh4zfhk. 11.

[53] Koenig, McCullough, and Larson, *Handbook of Religion and Health,* 71.

leaders prescribe rituals such as prayer as the sole solution to mental ill health, and to provide those solutions without further context or information regarding the individual's mental ill health.

The evil eye is also discussed in the Qur'an. Though cultural interpretations of the evil eye may seek protection from ornaments decorated with an eye, it is not rooted in religious texts, with many Muslims viewing that if one asks for protection from anything/anyone other than Allah, then this would amount to shirk or idolatry. Allah says in the Qur'an, chapter 68, verse 51, regarding the evil eye,

*"*The disbelievers almost strike you down with their looks when they hear the Qur'an. They say, 'He must be mad!' but truly it is nothing other than a Reminder for all peoples"[54]

There is a further belief often prevalent within Muslim communities that a lack of faith or "separation from the divine" can also be a cause of mental illness.[55] Bhui et al., detailed a report which surveyed Muslim women that found they believed that "a lack of faith [was] a cause of depression".[56] This was also found by Cinnirella and Loewenthal who found in their research that, "among suggested causes for depression and schizophrenia, religious factors were more important for depression than for schizophrenia".[57] This thesis examines the differences of opinion on various mental illnesses and disorders amongst Muslim men in the UK. For example, whether there are different views on anxiety and depression, more common disorders than on less common disorders. Similarly, Weatherhead and Daiches noted that participants in their study of Muslim views of mental health said that simply by accessing mental health services, they would be implying "that they had not been able to get satisfaction from their religion", adding to the argument that many within the Muslim community feel as though poor mental health is somehow caused by a lack of connection to one's faith.[58]

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[54] Abdel Haleem, *The Qur'an,* 386.
[55] Hooman Keshavarzi and Amber Haque, "Outlining a Psychotherapy Model for Enhancing Muslim Mental Health within an Islamic Context," *International Journal for the Psychology of Religion* 23, no. 3 (2013): 230–49, https://doi.org/10.1080/10508619.2012.712000. 233.
[56] Kamaldeep Bhui et al., "Ethnicity and Religious Coping with Mental Distress," *Journal of Mental Health* 17, no. 2 (January 1, 2008): 141–51, https://doi.org/10.1080/09638230701498408, 142.
[57] Kate Miriam Loewenthal and Marco Cinnirella, "Beliefs about the Efficacy of Religious, Medical and Psychotherapeutic Interventions for Depression and Schizophrenia among Women from Different Cultural–Religious Groups in Great Britain," *Transcultural Psychiatry* 36, no. 4 (December 1, 1999): 491–504, https://doi.org/10.1177/136346159903600408. 495.
[58] Stephen Weatherhead and Anna Daiches, "Muslim Views on Mental Health and Psychotherapy," *Psychology and Psychotherapy: Theory, Research and Practice* 83, no. 1 (2010): 75–89, https://doi.org/10.1348/147608309X467807. 82.

Whilst at the surface it may not seem problematic for individuals to believe that djinn and mental illness are somehow causal or interrelated, issues mainly arise when aiming to treat the sufferer. Though in Islamic texts djinn possession is spoken about, some of the effects, such as seizing and speaking in tongues, do not mirror that of symptoms of common mental illnesses such as depression and anxiety. [59]

Khalifa and Hardie emphasise the need for a multi-faceted, but medicine-centric approach to cases of alleged possession by a djinn. They say that "any underlying mental disorder should be treated by usual psychiatric methods", and go on to then emphasise that cultural beliefs around djinn possession should be respected by practitioners and not directly contradicted, in order to build up trust and give the patient the best care possible.[60] As will be mentioned later in this chapter, Muslims are often sceptical about attending and seeking therapy and care due to the fear that cultural and religious issues may not be understood. Djinn and possession may be one of the issues that if there was greater understanding of, and if were not directly contradicted, but paired with alternative treatments and diagnoses, there may be higher rates of Muslims wanting to seek help. Even those who acknowledge djinn possession say that cases of individuals who have been possessed are massively outnumbered by those exhibiting symptoms because of "physical or psychological" reasons.[61]

The methods to expel a djinn from the body are widely contested and can often be damaging to the individual undergoing the "treatment". Though Khalifa and Hardie state that expelling the djinn must only be done in "cases of real possession", this is not always the case and can leave those with mental illnesses scarred and with lifelong damage, even worsening conditions.[62] Those tasked with expelling the djinn may use a variety of methods, though the most common is through exorcisms. Khalifa and Hardie note that some so-called faith healers may even hit the possessed individual, 'claiming that it is the jinn that suffer the pain'.[63] They go on to mention that this practice is not permitted by Muslim scholars and not in line with Islam, including the Sunnah.[64] From this, we can ascertain that methods relating to djinn expulsion, though they may include religious words, are more cultural than

[59] Najat Khalifa and Tim Hardie, "Possession and Jinn," *Journal of the Royal Society of Medicine* 98, no. 8 (August 1, 2005): 351–53, https://doi.org/10.1177/014107680509800805, 351.
[60] Khalifa and Hardie, 352.
[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] Ibid.

religious. This study will examine cultural backgrounds and views of djinn in the context of mental illness to discover any correlations.

Dein et al, studied the understandings of djinn of Bangladeshis in East London. Though their study related to misfortune in general, they did examine understandings of mental illness. Furthermore, they discussed the roles of "folk healers" in the community. As mentioned previously, there is often disparity and sometimes confusion regarding which practices are from religion versus which practices have root in culture.[65] Though they do not give a definitive definition of what they mean by the term "folk healers", we can infer that they are traditional, community-based healers, who are not imams or faith leaders. Dein et al, do give examples of "folk remedies", such as olive oil, black seed oil or *zamzam* water.[66] *ZamZam* is water considered sacred by Muslims, taken from a well in Makkah said to have appeared to Hajar and Ismail miraculously in the desert. These remedies are not harmful to an individual, and as the study notes, GPs are often also consulted. When folk healers are utilised, Dein et al note that they often blur the lines between 'magic, herbal, and Islamic healing', and are not just turned to for treatment of illnesses but for causing harm to individuals.[67] They note where folk healers can cause harm by giving the case study of a Bangladeshi woman whose family did not notice the signs of depression in her, but in fact thought she was suffering from djinn possession. They took the woman to faith healers and spent in excess of £3,000 trying to cure her until a community elder insisted she was taken to see a doctor.[68] The process of seeing various healers and undergoing a multitude of treatments may not only be harmful to the sufferer, but also to the families, where "healers" may prey on the lack of knowledge or vulnerabilities of a community and give them false hope while simultaneously insisting on financial reimbursement. This has been a significant issue in many communities, with some being financially exploited for the services. In interviews, one participant noted his experience of coming across this issue in his work.

As this study interviews Muslim men who have various ethnic and cultural backgrounds, it is important to understand how mental health is perceived, diagnosed, and treated in other countries. The aforementioned study by Donnelly et al discussed the conceptualisation of

[65] Khalifa, Hardie, and Mullick, "Jinn and Psychiatry: Comparison of Beliefs among Muslims in Dhaka and Leicester," 32.
[66] Ibid, 42.
[67] Ibid.
[68] Ibid, 43.

mental health, especially depression, in the Middle East. It particularly examined the role of comorbidities in mental health disorders. Comorbidities are when two or more disorders or illnesses occur concurrently in an individual. Comorbidities do not necessarily have to be directly caused or linked to one another, though they are often related to one overarching primary condition. However, if one of the comorbidities is a mental health condition, they can sometimes make a physical condition worse. Donnelly et al noted this with patients suffering from cardiovascular diseases and depression, as they found that the depression made patients less able to maintain a healthy lifestyle, such as following a good diet and regular exercise, which would in turn worsen their cardiovascular issues. For future study, it would be interesting to see whether the prevalence of any mental health conditions began as a result of any physical illnesses.

Mental Health in the Muslim Community – Muslims in Wales

This section discusses mental health in the Muslim community in the UK with respect to trauma, Islamophobia, and access to therapy. It then further specifies to examine mental health in the context of Muslims in Wales in particular. It will look at comparatives and contrasts with the US Muslim population as much of the research already undertaken in this field has been in a US context. It will provide contemporary views on mental health in the Muslim community as well as examining historical Muslim approaches to mental illnesses in order to contextualise current opinions. Whilst this topic is under-researched, there does exist a few journals, namely the *Journal of Muslim Mental Health*, that seek to provide a platform for this type of work. Though this thesis concentrated on Muslims living in south Wales, for the section of the literature review, I have had to concentrate on Wales more generally as there is no relevant literature other than statistics for south Wales itself.

Though mental health in the Muslim community is currently stigmatised and often seen as a taboo, early and Medieval Muslim and Islamic thinkers were pioneers in the treatment of mental and psychological disorders. Al-Razi (854-925 AD), Ibn Sina (Avicenna) (980-1037 AD), and al-Balkhi (850-934 AD) were all historic thinkers who contributed to early understandings of treating mental ill health. Al-Balkhi was writing during the era of the Islamic Golden Age and his book *Masalih al-Abdan wa al-Anfus* (Sustenance for Bodies and Souls) introduced concepts of mental health and related them to physical health, many of

which have been of interest to modern day scholars.[69] Al-Balkhi is referred to as a "great scholar of psychosomatic medicine" and his approach is preventative as well as reactive.[70] It is notable that he discusses the benefits of music in relaxation and promoting physical and mental wellbeing when many current Muslim scholars believe that music is forbidden.[71] Al-Balkhi also discusses the role of comorbidities in relation to mental health, saying that 'mental pain leads to corporeal diseases', acknowledging the physical symptoms that can often occur with mental disorders such as those that occur with anxiety, for example heart palpitations or muscle aches.[72]

Ibn Sina, known in the West as Avicenna, was also integral in the development of mental health in early Muslim communities. His book *al-qanun fi al-tibb* (Canon of Medicine) was accepted and considered the "major textbook of medicine in Europe for centuries".[73] He understood that mental illnesses originated in the brain. He also explored the use of drugs in association with some psychiatric disorders.[74]

According to Mohit's study of the historical developments of mental health and psychiatry in the Middle East, in the ninth and tenth centuries AD, the first humane psychiatric hospitals were established in the Middle East approximately three hundred years before they were built in the West.[75] These hospitals were spread across the Islamic Empire, most notably in Baghdad, Damascus, and Cairo. It is the methods of treatment which are the most interesting to note. As Mohit mentioned, these hospitals were the first to be considered "humane" for the mentally unwell, and the treatments focused on "therapy, reassurance and support", in addition to the relationships between the body and the mind.[76] As Al-Balkhi did, many of these treatments also included the use of music.[77] Currently, there are some Muslim therapists in the UK who are approaching therapy with an Islamic approach more suited to British Muslims. Ghazalah Mir at the University of Leeds has created an Islamic-based form

[69] al-Balkhī and Badri, *Abu Zayd AlBalkhi's Sustenance of the Soul*. 6.
[70] Ibid.
[71] Ibid.
[72] Ibid. 9.; "Generalised Anxiety Disorder in Adults - Symptoms," nhs.uk, October 3, 2018, https://www.nhs.uk/conditions/generalised-anxiety-disorder/symptoms/.

[73] A. Mohit, "Mental Health and Psychiatry in the Middle East: Historical Development," *Eastern Mediterranean Health Journal = La Revue De Sante De La Mediterranee Orientale = Al-Majallah Al-Sihhiyah Li-Sharq Al-Mutawassit* 7, no. 3 (May 2001): 336–47. 342.

[74] Mostafa Araj-Khodaei et al., "Avicenna (980-1032CE): The Pioneer in Treatment of Depression," *Transylvanian Review* 25 (May 1, 2017): 4377–89, 4379.
[75] Mohit, "Mental Health and Psychiatry in the Middle East," 342.
[76] Ibid.
[77] Ibid.

of Cognitive Behavioural Therapy (CBT), successfully being able to merge psychotherapy practices with aspects of the Muslim faith.[78] Likewise, Hanif Bobat stated the increased use of integrated therapies such as "mosque therapy" and "Tahajjad therapy" which have roots in Islam and combine both religion and psychotherapeutic practices".[79],[80]

Though, Muslim scholars in the past had accurate, often medically-sound knowledge of mental illness, it appears that current thinking in this area has almost gone backwards; with superstition, religion, and culture becoming intertwined and difficult to unpack. Following this period, there was a decline in mental health treatments and care, as well as overall medicine for ordinary people.[81] When modern medicine began to be used in the East, psychiatric hospitals were formed from their European counterparts, though did not have the same treatments and methods of those from the so-called Golden Islamic Age. Psychiatry in the Middle East has gone through many changes under colonialism, revolution, and independence, though current treatments do not appear to have the same compassion as seen in the past.

Empirical gap in the research

Many works exploring mental health in Muslim communities focus on those in the USA. The USA and the UK differ vastly in the ethnic makeup and cultural backgrounds of their respective Muslim communities. Due to the UK's colonial past in the South Asian subcontinent, many of the Muslims have roots in present day India, Pakistan, and Bangladesh and came to the UK in the 1940s, 50s, and 60s, to work and subsequently built their families here. In fact, those from South Asian backgrounds make up 68% percent of Muslims in the UK. These individuals were from poorer circumstances, coming to the UK to seek better financial stability to send money "*back home"*.[82] They mainly worked in businesses such as textile factories in the UK in what are now predominantly Muslim areas such as East London, or parts of Birmingham. Comparatively, Muslims in the USA generally came from richer, more educated upbringings, choosing to come to the USA to open

[78] "Mental Health Therapy for Muslims Embraces Religion," *BBC News*, February 12, 2017, sec. England, https://www.bbc.com/news/uk-england-38932954.
[79] Bobat, "A User-Led Research Project into Mosque," 10.
[80] Tahajjad/Tahajjud is a voluntary nightly prayer in Islam, not part of the five prescribed daily prayers.
[81] Mohit, "Mental Health and Psychiatry in the Middle East," 342.
[82] Ibid, 24.

businesses or for schooling. Cardiff and South Wales provide an interesting difference to the rest of the UK, as will be explored later. The oldest communities in these areas are of Somali and Yemeni descent. This is incredibly important to emphasise in order to understand the nuances between cultural differences and understandings between Muslims in Wales, and Muslims in England and other areas of the UK.

This difference in background contributes significantly to an individual's understanding of Islam, and perhaps more prominently in the US, the separation between religion and culture. Muslims in the USA come from more diverse ethnic backgrounds than those in the UK, thereby making it more difficult for one culture to become so intertwined with the religion.

By neglecting to understand these cultural differences, literature that focuses primarily on the US context cannot necessarily be applied to the UK. context. Therefore, more research is needed into the relationship between Muslims in the UK. and mental health. From the extensive research as detailed here, it is evident that therein lies significant gaps in mental health research in the UK. regarding ethnicity, culture, and religion, specifically regarding Islam. Where Islam and Muslims are studied, they are primarily focused on Muslim women.

The Role of the Community

There is also evidence that community has a role to play in the diagnoses of health conditions. One study in the USA looked at the role the community played for Seventh Day Adventists. In other words, Seventh-Day Adventist women simply had their breast cancers diagnosed at an earlier stage than non-Adventist women. The close-knit family and social community of Seventh Day Adventists, along with their focus on health, may have led to early diagnosis. However, if there is increased understanding and knowledge of mental illness within the community, conditions may be easier to treat and recognise. One study of Muslim Faith leaders in the UK authored by Meran and Mason did note that imams and other Islamic professionals, could be the key to dismantling the stigma in the Muslim community on mental health. They are at the forefront of issues with the community, often being the sole source of comfort and advice for Muslims experiencing "emotional and psychiatric

difficulty".[83] Many studies have identified that Muslims may in fact turn to imams and other religious leaders before speaking with healthcare professionals, including doctors.[84] This shows the pressing and important need for Muslim professionals to be trained in mental illness and to be able to identify the signs, perhaps thereby preventing worsening conditions or suicide. The study also identifies that imams may have a better understanding, and a less stigmatised view of mental illness compared with the general Muslim population. They came to this conclusion based on previous studies suggesting that those with direct experiences of mental illness are more likely to be accepting and understanding of the conditions.[85]

The Stigma around Mental Health

Throughout this thesis, discussions of stigma are used, and the definition utilised is as follows. As the points discussing stigma in this thesis are mostly related to mental health and mental illness, I have considered definitions from appropriate organisations and theorists. The mental health organisation MIND states that stigma can be understood as "ignorance about mental health problems, prejudicial attitudes around mental health, and discrimination towards people with mental health problems". [86] Link and Phelan discussed how in academic works, there are varying definitions of stigma, ranging from "a mark of disgrace" to "an attribute that is deeply discrediting".[87] They note that due to research on stigma being multidisciplinary, there will be differences in the emphasis of interest in the term, and have attempted to specify "a conceptualisation of stigma that includes many of the concerns that people working in this area of research share".[88] Their ultimate definition of stigma is, "stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them."[89] Both definitions, by MIND and Link and Phelen, are important to understand as the former is one which is focused on mental health and has been informed by those with lived experience, and the latter is important within an academic setting.

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[83] Sazan; Mason Meran, "Muslim Faith Leaders: De Facto Mental Health Providers and Key Allies in Dismantling Barriers Preventing British Muslims from Accessing Mental Health Care," *Journal of Muslim Mental Health* 13, no. 2 (Winter 2019), https://doi.org/10.3998/jmmh.10381607.0013, 202.
[84] Ibid.
[85] Ibid.
[86] 'Introduction | Attitudes to Mental Illness 2023', accessed 6 February 2025, https://www.mind.org.uk/about-us/our-strategy/tackling-mental-health-stigma/attitudes-to-mental-illness-2023/introduction/.
[87] Bruce G. Link and Jo C. Phelan, 'Conceptualizing Stigma', *Annual Review of Sociology* 27 (2001): 363–85, https://www.jstor.org/stable/2678626. 264
[88] Ibid, 365.
[89] Ibid, 377.

A pressing issue for Muslims when speaking about mental health is the stigma which is prevalent within the community, stemming from a lack of understanding about the conditions. Meran and Mason noted that "high levels of mental health stigma have been specifically found within Muslim communities".[90] Bobat noted stigma as an issue in his study of Muslim men in North Manchester with one participant who discussed "the lack of sensitivity" displayed by other Muslim men when an individual is disclosing mental health issues, with words such as "Pagal" being "uttered and whispered" around the sufferer. [91],[92]

Ciftci et al. found that factors such as "family honour, shame, and moral responsibility" are contributing factors to accessing (or not accessing) psychiatric services.[93] Whether it is seen as acceptable or not in the community is something that affects an individual's willingness to seek help.

In a 2009 study into Muslim views on mental health and psychotherapy, Weatherhead and Daiches noted that feelings of stigma were a barrier which prevented Muslims from accessing mental health services.[94] They described the sense and feelings of stigma prevalent within the Muslim community as "powerful", summing up the impact this kind of view has on access and opinions of mental health treatment and services.[95]

McKenzie et al discuss the gendered dimensions of stigma surrounding mental illness.[96] They note that worldwide suicide rates for men are more than twice that of women, and that stigma inhibits men from seeking help and disclosing symptoms related to mental ill health. McKenzie et al also add that men can be, "more vulnerable to stigmatised attitudes and beliefs towards mental illness", as experiencing these illnesses do not align with masculine norms such as "strength and self-reliance", since mental illnesses can be associated with weakness.[97] These norms may be exacerbated within Muslim communities where traditional

[90] Ibid.
[91] Pagal is a Hindi word for 'crazy' or 'mad'.
[92] Bobat, "A User-Led Research Project into Mosque," 8.
[93] Ciftci, "Mental Health Stigma in the Muslim Community." 22.
[94] Weatherhead and Daiches, "Muslim Views on Mental Health and Psychotherapy." 82.
[95] Ibid. 86.
[96] Sarah K. McKenzie et al., "Men's Experiences of Mental Illness Stigma Across the Lifespan: A Scoping Review," *American Journal of Men's Health* 16, no. 1 (February 7, 2022): 15579883221074789, https://doi.org/10.1177/15579883221074789.1.
[97] McKenzie et al., "Men's Experiences of Mental Illness," 2.

masculine roles are entrenched in many cultural backgrounds. This is seen within the later interviews of this thesis.

Not only do these norms have an effect on men's mental health, but McKenzie et al. also examined that men themselves hold more stigmatising views than woman towards mental illnesses; namely, depression, anxiety, and those who have taken their own lives.[98] This suggests that in addition to masculine norms increasing stigma of mental illness, men hold stigmatising views of mental illnesses which could lead to self-stigmatisation if they were suffering with mental illness. Interestingly, McKenzie et al mention generational differences in men, reporting that younger men had the "highest levels of social stigma toward men's suicide and depression" (in comparison to men of other ages).[99] This differs from attitudes within the Muslim community, with the men I interviewed saying that there was an increased understanding and acceptance of mental ill health amongst younger generations, and suggested that the older generations perhaps lacked understanding in this area.

Islamophobia and Trauma as a Cause and Effect

One issue often discussed in relation to mental health within the Muslim community is the negative impact of Islamophobia. For the purposes of this thesis, the definition which will be used is that of the All-Party Parliamentary Group on British Muslims. This definition states that *"*Islamophobia is rooted in racism and is a type of racism that targets expressions of Muslimness or perceived Muslimness"[100]. Though this definition is yet to be accepted by the UK government, it is one which is supported by many academics. The term Islamophobia was first initiated into discourse in the U.K., by the 1997 Runnymede Trust report entitled "Islamophobia: A Challenge for Us All" which recognised that over the previous 20 years (prior to 1997), Muslims in the UK were experiencing increasing forms of prejudice,

[98] McKenzie et al., "Men's Experiences of Mental Illness," 2.
[99] McKenzie et al., "Men's Experiences of Mental Illness," 2.
[100] 'HCL0054 - Evidence on Islamophobia', accessed 10 February 2025, https://committees.parliament.uk/writtenevidence/103559/html/.

exclusion, and violence.[101] The term Islamophobia can be a contested one, with some local councils adopting the definitions of the term, while the government rejects it.[102]

Islamophobia is something which not only may potentially contribute to mental health issues through stress and trauma after Islamophobic incidents but also stops many Muslims from seeking help. This has been seen in the US context post-9/11 but the same has not been examined in a British context, either post 9/11 or post-7/7. Laird et al. argue that Islamophobia can contribute to health disparities amongst Muslims as a minority group.[103] They concluded that social and political dynamics impact the health of Muslim children in both the USA and the U.K. and called for "significant cultural and institutional adjustments in health care settings and further research studies to provide specific data to address health disparities for these growing and diverse populations".[104]

There is often an internal debate when Muslims wish to seek therapy of whether to go to a Muslim or non-Muslim counsellor. They fear that the former could judge them should they confess to something regarded or interpreted as "sinful" or not Islamic while the latter could display Islamophobic sentiments or simply not understand the importance of religious rituals such as prayer and fasting.[105] Inayat identified six key factors which could be seen as barriers for Muslims wanting to access mental health services. They are:

- "mistrust of service providers,
- fear of treatment,
- fear of racism and discrimination
- language barriers
- differences in communication
- issues of culture"[106]

[101] Runnymede Trust, "Islamophobia: A Challenge for Us All" (Commission on British Muslims and Islamophobia, 1997), https://www.runnymedetrust.org/companies/17/74/Islamophobia-A-Challenge-for-Us-All.html. 1.
[102] Gabriella Swerling, 'One in Seven Councils Adopts Islamophobia Definition Rejected over Free Speech Fears', *The Telegraph*, 18 September 2023, https://www.telegraph.co.uk/politics/2023/09/18/councils-islamophobia-definition-government-free-speech/.
[103] Lance D. Laird et al., "Muslim Patients and Health Disparities in the UK and the US," *Archives of Disease in Childhood* 92, no. 10 (October 2007): 922–26, https://doi.org/10.1136/adc.2006.104364. 924.
[104] Ibid, 922.
[105] Keshavarzi and Haque, "Outlining a Psychotherapy Model for Enhancing Muslim Mental Health within an Islamic Context," 231.
[106] Qulsoom Inayat, "Islamophobia and the Therapeutic Dialogue: Some Reflections," *Counselling Psychology Quarterly* 20, no. 3 (September 1, 2007): 287–93, https://doi.org/10.1080/09515070701567804, 289.

This study explores whether Inayat's identification is true in the context of Muslim men in south Wales, and if there are other factors which contribute to an underutilisation of mental health services such as cultural or age barriers. This is explored in detail in the Data chapter of this thesis. Inayat recommends that in order for these factors to change, counsellors should ensure they are sensitive and sympathetic to their Muslim patients' needs, particularly due to the current political climate in the UK.[107] Keshavarzi and Haque outlined a psychotherapy model within an Islamic context which built upon Inayat's identification of six barriers. They noted that in Western countries, and indeed Muslim countries, religion and mental health services are not seldom integrated.[108] Tarabi notes that Pakistani Muslim men with psychological issues 'underutilise mental health services in the UK'.[109] He suggests that this issue could be addressed with an increased focus on the incorporation of religious and cultural beliefs into therapeutic practices.

A recent policy briefing by the Centre for Mental Health and Kings College London examined racism as it relates to intergenerational consequences for parents and their children.[110] They do not explicitly mention racism as a barrier to seeking mental health support; rather, they suggest that racism is a determinant for poorer mental health outcomes.

Many Muslims in the UK suffer from vicarious trauma through the concept of the *ummah*. As a community that prides itself on concepts of togetherness, Muslims are often encouraged to feel empathy with other Muslims, especially those suffering, across the world. So, if there is a conflict or issue amongst Muslims in one area, other Muslims may be impacted by this, despite living elsewhere. The *Parable of the Believer,* a hadith, emphasises this.

> "The similitude of believers in regard to mutual love, affection, fellow-feeling is that of one body; when any limb of it aches, the whole-body aches, because of sleeplessness and fever."- Sahih Muslim 2586[111]

[107] Ibid, 292.
[108] Keshavarzi and Haque, "Outlining a Psychotherapy Model for Enhancing Muslim Mental Health within an Islamic Context." 231.
[109] Tarabi "Exploring the Experience of Second Generation Pakistani Muslim Men in Individual CBT." 29.
[110] Kadra Abdinaser and Yasmin Ahmadzadeh, "A CONSTANT BATTLE: EXPLORING THE INTERGENERATIONAL CONSEQUENCES OF RACISM IN THE UK" (London: Centre for Mental Health, Kings College London, October 2023), https://www.centreformentalhealth.org.uk/wp-content/uploads/2023/10/CentreforMH_Briefing62AConstantBattleFinal_0.pdf. 4.
[111] "Sahih Muslim 2586a - The Book of Virtue, Enjoining Good Manners, and Joining of the Ties of Kinship - كتاب البر والصلة والآداب - Sunnah.Com - Sayings and Teachings of Prophet Muhammad (صلى الله عليه وسلم)," accessed February 25, 2023, https://sunnah.com/muslim:2586a.

Many Muslims in the UK are themselves immigrants, or second or third generation immigrants with family still in South Asia, Africa, and the Middle East. When war or other trauma occurs in those areas, UK Muslims feel it vicariously.[112] This is in addition to those who may have experienced this trauma first-hand as individuals that come to the UK as refugees or asylum seekers. Public Health Wales noted in 2023 that 'asylum-seekers, refugees, and other displaced peoples have poorer mental health outcomes than those of the general population'.[113] As the numbers of asylum claims in the U.K., are increasing, particularly since the war in Ukraine, it would be pertinent to begin to research the impact of this on mental health.[114]

When examining the relationship between religion and mental health, it is important to examine the theories of psychologists. Though this research is sociological in its design and understanding, one cannot discuss mental health, or mental health and religion, without acknowledging the ideas and input of psychologists and Psychology. Some psychologists see religion as a psychological construct; something that the mentally ill are drawn to because of their conditions, rather than seeing it as an aid to recovery or even legitimate ideas about the world. Furthermore, Freud's general perceptions of religion related to the idea that religious individuals were suffering from a parental complex stemming from the belief of God as a magnified father figure.

As this is study may fit within sociological frameworks, it is also important to analyse the approaches to religion as a social construct. Emile Durkheim, a prominent social scientist, was one of the first Europeans studying the relationship between mental health and religion. However, in the case of many studies, he focuses on the Judeo-Christian religions that were more prominent in Europe during his time. In 1897, Durkheim suggested that "spiritual commitment and religious connection" may add to wellbeing, but also religion can provide meaning to the wider world.[115] However, recent research suggests that this may differ

[112] Faima Bakar, "Muslims Experience 'shared Suffering' When Other Muslims Go through Trauma," *Metro* (blog), March 2, 2020, https://metro.co.uk/2020/03/02/muslims-experience-shared-suffering-muslims-go-trauma-12222128/.
[113] 'Refugees and Asylum-Seekers Are among the Most Vulnerable Members of Society Having Poorer Mental Health than the General Population.', Public Health Wales, accessed 28 January 2024, https://phw.nhs.wales/news/refugees-and-asylum-seekers-are-among-the-most-vulnerable-members-of-society-having-poorer-mental-health-than-the-general-population/.
[114] Georgina Sturge, 'Asylum Statistics', 28 January 2024, https://commonslibrary.parliament.uk/research-briefings/sn01403/.
[115] Gearing and Alonzo, "Religion and Suicide," 2478.

depending on the religion concerned.[116] Durkheim also discussed the importance of social cohesion for well-being, something which is explored through this study's interviews; acknowledging the role that the mosque and community can have in supporting an individual's mental health and how the Coronavirus pandemic may have altered this. In Durkheim's book Suicide, he noted that more men than women die by suicide, as the latter are most integrated into the family; thus, finding support within them.[117] Furthermore, in the case of Muslim men, the social cohesion mentioned by Durkheim could be represented by the mosque and its place in the community. By using this analogy, it will be interesting to discover the impact of mosque closures on mental health due to the Coronavirus pandemic. In 2024, as we move away from the lockdowns of 2020 and 2021, and the pandemic more generally, it may also be suitable for further research to examine the positive roles that mosques can play in good mental health more generally amongst the congregation.

The Welsh Context – Muslims in Wales

According to Public Health Wales, approximately a quarter of the population of Wales experiences problems relating to mental ill health.[118] With more awareness of conditions, and an increase in external stressors and pressures, such as issues relating to the COVID-19 pandemic, this number may be larger than originally thought. Public Health Wales' 2020 report on *Improving Mental Wellbeing and Building Resilience* discussed a variety of factors on mental wellbeing with the statistics deriving from surveys such as *the National Survey for Wales, Annual Population Survey, and the School Health Research Network.*[119] *Because* this thesis focuses on the mental health of Muslim men living in south Wales, it is important to understand the context of general mental health in Wales since this also impacts Muslims in Wales more generally. The report found that though rates of *life satisfaction* had increased between 2013 to 2018, the rates were on the whole lower than those seen in England, Scotland, and Northern Ireland.

[116] Ibid, 2479
[117] Howard I. Kushner and Claire E. Sterk, "The Limits of Social Capital: Durkheim, Suicide, and Social Cohesion," *American Journal of Public Health* 95, no. 7 (July 2005): 1139–43, https://doi.org/10.2105/AJPH.2004.053314. 1141.
[118] Observatory, "Public Health Wales Observatory - Mental Wellbeing in Wales (2020)."
[119] Though this report was released in 2020, it does not include information regarding mental health under the COVID-19 pandemic.

Muslims make up 6.5% of the population of England and Wales, amounting to 67,000 Muslims in Wales according to the 2021 census.[120] Though the percentage of Muslims in Wales may seem low, the population is growing and Muslims have been a part of the fabric of Welsh life since the 12th century.[121] However, the Welsh Muslim population really began to take shape in the mid-19th century due to the emergence of the shipping industry utilising the ports of south Wales.[122] Many Muslims were recruited from colonial lands, in particular India, and predominantly Muslim countries such as Yemen, Somalia, and Somaliland. In Cardiff, boarding houses were created as accommodation for this growing population of seafarers.[123] Bute Street in Cardiff, and subsequently the Alice Street mosque became synonymous with these communities and remain to this day heavily Muslim areas. As many Muslims from the aforementioned ethnic backgrounds have been in Cardiff and south Wales for generations, it may impact views and experiences of mental health, particularly how they relate to notions of identity and belonging. 'There is a sense of belonging where the docks is [sic] concerned', said one Somali ex-Seafarer in Butetown, Cardiff.[124] The majority of Somalis in Cardiff are Somalilanders, hailing from Somaliland rather than Somalia, an important distinction to make, as many Somalilanders in the city have successfully fought for Cardiff council to recognise the territory.[125]

It is due to the intricacies and uniqueness of the Welsh Muslim community that this thesis will concentrate on the mental health of Muslims in Wales. The elements that make up the Welsh Muslim community including its history and sense of Welsh nationalism means that their experiences of mental health, in particular relating to identity sentiments, could be wholly unique; especially in comparison to their English counterparts. The community itself can contribute to an individual's mental wellbeing, and religious communities where places of worship serve as community hubs, are of importance. Gearing and Alonzo found that members of religious communities can act as "a bridge to mental health services", providing support and links to those who otherwise would not be reached.[126]

[120] "Ethnic Group, National Identity, Language and Religion in Wales (Census 2021)."
[121] Delyth Jewell, "Ramadan: Delyth Jewell on Islam in Wales," Wales Arts Review, May 5, 2019, http://www.walesartsreview.org/ramadan-delyth-jewell-on-islam-in-wales/.
[122] Gilliat-Ray and Mellor, "Bilād Al-Welsh (Land of the Welsh)." 452.
[123] Ibid.
[124] Guardian Staff, "Somalis in Cardiff," the Guardian, January 23, 2006, http://www.theguardian.com/uk/2006/jan/23/britishidentity.features11.
[125] Ruth Mosalski, "Cardiff Becomes Only Second UK Council to Recognise the Republic of Somaliland," WalesOnline, March 26, 2015, http://www.walesonline.co.uk/news/wales-news/somaliland-recognised-by-cardiff-council-8930027.
[126] Gearing and Alonzo, "Religion and Suicide", 2482.

There are no specific statistics related to Muslim deprivation in south Wales. However there exists factors in England and Wales which contribute to overall deprivation of Muslims, and in turn may contribute to poorer mental health outcomes. Muslims make up 18% of the prison population in England and Wales, despite only making up 7% of the general population.[127] According to the 2021 census, Muslims in England and Wales were also more likely to live in social rented housing, and four times more likely to live in overcrowded homes.[128] Muslims also had the lowest rate of employment, and highest rates of economic inactivity.[129] The census also found that 61% of Muslims live in the 40% most deprived areas of England and Wales.[130] Furthermore, Muslims in the UK have the highest levels of illness and disability (16% for women, 13% for men).[131] These factors all contribute to poor mental health for the Muslim community. As a community who have some of the worst physical health outcomes of any other minority group in the UK, this may also be mirrored in mental health outcomes. Links between deprivation and mental health have emerged, with the government asserting,

> "It is well established that deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly less resource than others) is associated with poorer health, including mental health."[132]

This section has looked at the existing literature surrounding mental health in the UK Muslim community, with a focus on Muslims in Wales. While these topics are limited in research, this thesis will add a much-needed examination to the small, but growing, field. The unique context of Muslims in Wales, specifically south Wales, in terms of their history and

[127] Georgina Sturge, 'UK Prison Population Statistics' (House of Commons Library, 8 September 2023), https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf. 15.
[128] 'Religion by Housing, Health, Employment, and Education, England and Wales - Office for National Statistics', accessed 25 January 2024, https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/religionbyhousinghealthemploymentandeducationenglandandwales/census2021.
[129] Ibid.
[130] Aamna Mohdin and Aamna Mohdin Community affairs correspondent, 'Census Says 39% of Muslims Live in Most Deprived Areas of England and Wales', *The Guardian*, 30 November 2022, sec. World news, https://www.theguardian.com/world/2022/nov/30/census-says-39-of-muslims-live-in-most-deprived-areas-of-england-and-wales.
[131] Feryad Hussain, "The Mental Health of Muslims in Britain: Relevant Therapeutic Concepts," *International Journal of Mental Health* 38, no. 2 (2009): 21–36, http://www.jstor.org.ezproxy.uwtsd.ac.uk/stable/41345282. 23.
[132] '2. Mental Health: Environmental Factors', GOV.UK, accessed 25 January 2024, https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place.

demographic and ethnic make-up, provides an interesting background through which to study Muslim men's mental health.

Male Mental Health and Muslim Men

This section will examine the experiences of mental health amongst Muslim men in the wider U.K., but where available, with a focus on Wales. Much of the data available on male mental health speaks to instances and statistics around suicide. This may be because it is a figure which encapsulates a gender disparity around mental health. In other figures, such as the prevalence of anxiety or depression, women have higher rates.[133]

To understand the impact that a Muslim man's gender identity may have on their relationship with mental illness, one must consider both the religious and cultural dichotomies at play. This thesis discusses themes of masculinity, and how this, coupled with an individual's religious and/or cultural background, has shaped their views and experiences of mental ill health. If an individual views their role as a Muslim male to be that of a protector repressing weakness, then this could mean one neglects to show emotion, leading to possible negative consequences for their mental wellbeing.[134]

As this research focuses on the experiences of men, it is important to define any factors which may affect their views and opinions of mental health as a result of their sex and the associated religious or cultural roles or requirements. In her book *Masculinities,* Connell discusses Pleck's idea that within sex role theory, 'men's and women's positions [are] complementary' rather than hierarchal.[135] Within the British Muslim context, this analysis can simultaneously be correct and incorrect depending on culture. Islam suggests that men and women may have different roles, but one does not have power over another. However, cultural interpretations in patriarchal societies may overpower religious notions and provide a means for a sex hierarchy. Connell however does not attach much merit to sex-role theory, stating that it 'underplays inequality and power'. She also states that this theory is

[133] 'Men and Women: Statistics', accessed 23 January 2024, https://www.mentalhealth.org.uk/explore-mental-health/statistics/men-women-statistics.
[134] R.W. Connell, *Masculinities* (Second Edition) (California: Polity, 2005), 13.
[135] Ibid. 25.

reductionist, categorising gender in two, 'exaggerating differences between men and women'.[136] However, within the British Muslim community, traditional sex roles still exist, with men often taking on a provider role.

In De Sondy's book, *The Crisis of Islamic Masculinities,* he discusses the effect of perceived and existing notions of masculinity within Islamic communities.[137] Though De Sondy's work concentrates on notions of masculinity in the Qur'an as well as figures in Indian and Pakistani history, it has applicability to the current British and Welsh Muslim contexts due to the ethnic makeup of the Muslim population which is mainly from the South Asian subcontinent. Though, as mentioned previously, Cardiff has a different ethnic makeup of Muslims than other areas of the UK, it does have a high South Asian population. De Sondy also notes the importance of studies which look at different cultural variants of Islam, as those based on 'Arab lands have often dominated discussions'.[138] Ideas of Islamic masculinity may vary from culture to culture; therefore, there is a need to understand the backgrounds of the participants of this study, and how their cultural beliefs may shape these ideas.[139] De Sondy observed that the majority of studies which look at Muslim men and examine their masculinity are held because of the effect that masculinity can have on women, rather than examining them in their own right.[140] However, this study seeks to understand Muslim men independent of their effect on femininity, and rather with regard to perceived cultural and Islamic masculine and feminine roles which may have an impact on experiences and views of mental health.

Whilst there is not a wealth of data available which examines men's mental health in Wales, some statistics do exist. According to the Welsh government's 2016 Welsh Health Survey, there is a higher percentage of women than men being treated for any mental health condition (MHF).[141] When comparing this with national statistics, it is probably because men are less likely to seek help, thereby having higher suicide rates.[142] However, Public Health Wales reported that males they surveyed experienced lower levels of anxiety.[143] As the Welsh

[136] Ibid, 26.
[137] Amanullah De Sondy, *The Crisis of Islamic Masculinities* (London: Bloomsbury, 2015).
[138] Ibid, 4.
[139] Ibid, 8.
[140] Ibid. 4.
[141] Mental Health Foundation, "Mental Health in Wales: Fundamental Facts 2016," accessed August 6, 2020, https://www.mentalhealth.org.uk/sites/default/files/FF16%20Wales.pdf.
[142] "Suicide Facts and Figures," *Samaritans*, accessed August 6, 2020, https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/.
[143] Observatory, "Public Health Wales Observatory - Mental Wellbeing in Wales (2020)."

Health Survey indicates, men are less likely to speak about mental health conditions, perhaps going so far as to not disclose any conditions they may have, even on an anonymous survey.

According to the Samaritans, as the only agency which collates suicide rates, middle-aged men in England and Wales, specifically those aged 45-49, had the highest rates of suicide deaths for any age group, at 27.1 per 100,000 men.[144] The overall figure for male suicides of any age group was 16.9% per 100,000 in 2019, the highest rate since the year 2000. It is examined later in this thesis whether there are parallels for this with a cross-section of ages of Muslim men.

In a 2019 report by the Muslim Youth Helpline, I found that 40% of young Muslim men (aged 16-24) did not seek help/speak to anyone when they last had a mental health issue.[145] Through the interviews, I asked questions to my participants about whom they may speak to about their issues, and many discussed they felt they could not talk to anyone. The report also found that 27% of those surveyed knew someone directly or indirectly who had died by suicide.

While it is imperative not to conflate BAME/BME/ethnic minorities and Muslim, there has been focus on BME men not seeking support for mental health issues. This issue has gained traction in recent years. According to a report by charities MIND, The Afiya Trust and Centre for Mental Health, there exists significant inequalities in mental health experienced by those from minority ethnic backgrounds. They found that most significantly, the largest inequality in mental health care was experienced by black men who were severely overrepresented in the "hard end of services", such as imprisonment and being detained under the Mental Health Act.[146]

As discussed earlier, Muslims are less likely to seek help through counselling, therapy, or other means. When factoring in the intersectionality of being both Muslim and BAME/BME, and especially from the black community, it may prevent black and BAME Muslims from getting support. This, in turn, can lead to higher rates of suicide and more severe disorders as there would be no one to be able to spot the initial signs of mental illness. As Koenig

[144] "Suicide Facts and Figures."
[145] Jamilla Hekmoun et al., 'Muslim Youth: What's The Issue?' (Muslim Youth Helpline, n.d.), accessed 9 June 2020.
[146] LankellyChase Foundation et al., "Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change" (Confluence Partnerships, 2014), 7.

notes, 92% of psychiatrists surveyed in London believed "that religion and mental illness were connected, and that religious issues should be addressed in treatment".[147] Attitudes such as these could be a further barrier for Muslims seeking help for mental illnesses. If psychiatrists have a bias against religion, then this may stop individuals seeking help, especially as rates of Islamophobia are increasing.[148]

In a Canadian study, Ogrodniczuk et al noted that symptoms of mental illness can manifest differently in men. Whilst it is commonly seen that the symptoms of depression include fatigue, low mood, an inability to complete day-to-day activities, in men the symptoms can display differently with symptoms such as "irritability, anger, hostility [and] aggressiveness" amongst others.[149] This is especially relevant because some of those symptoms are often attributed to ideas of what masculinity should be – for example, being aggressive. These ideals of masculinity can also lead to men not wanting to come forward about their mental illness or mental difficulties for fear of them being seen as weak. Though this study was conducted in the Canadian context, it is a useful to notice how different mental health conditions can manifest in different genders.

Immigration

As part of this study, interviews will be conducted with men of all backgrounds and ethnicities, including refugees. In recent years, subsequent wars in the Middle East and other mainly Islamic nations have meant there has been an increase in Muslim refugees to the UK, with Wales in particular offering resettlement schemes. The Welsh government has committed to 'making Wales a nation of sanctuary for all who choose to make it their home'.[150] Hussain has noted that the UK population is currently evolving due to the 'changing demographics of migrant populations' entering the country.[151] Therefore, the effect, whether long-term or short-term, on mental health research must be acknowledged. Many refugees suffer from mental ill health due to the stresses that come from war trauma and resettlement. One issue that can prevail from resettlement is the lack of opportunities

[147] Koenig, McCullough, and Larson, *Handbook of Religion and Health*. 72.
[148] "Islamophobia Awareness Month," accessed December 5, 2023, https://www.libdems.org.uk/news/article/anti-islamophobia-month.
[149] John Ogrodniczuk et al., "Men's Mental Health: Spaces and Places That Work for Men," *Canadian Family Physician* 62, no. 6 (June 1, 2016): 463–64, https://www.cfp.ca/content/62/6/463. 463.
[150] "New Refugee and Asylum Seeker Plan for Wales Launched," GOV.WALES, accessed February 9, 2021, https://gov.wales/new-refugee-and-asylum-seeker-plan-wales-launched.
[151] Hussain, "The Mental Health of Muslims in Britain: Relevant Therapeutic Concepts."

one may find in their new country, for example a lack of employment. This can lead to further mental health problems in men as they can no longer fulfil traditional masculine roles such as providing financial sustainability for their family and being able to protect one's family from attack or oppression, which can fuel the same results.[152] The former may also mean that refugee men may have to rely on the benefits system. As Thamotharampillai et al noted, men from refugee backgrounds are 'significantly under-represented in mental health research'. It is not only migration related to fleeing war that can contribute to mental ill health, but also immigration in general. As Lim et al, note, 'migration itself is an important risk factor for psychiatric disorders, including posttraumatic stress disorder and dissociation'.[153] They give the example of Moroccans in the Netherlands who, though Morocco is not in a conflict zone, have found to be at further increased risk of developing mental illnesses – in this instance, it was schizophrenia spectrum disorders.[154]

In my aforementioned 2019 study, my colleagues and I noted some issues that were more prevalent for Muslim men, such as pornography addiction, drug abuse, and addiction.[155] The report also found that 22% of men surveyed had had suicidal thoughts or ideations, and 8% had self-harmed.[156]

A 2001 study by Bobat examined the benefits of Muslim men with severe mental health problems found from attending the mosque.[157] The research was conducted in collaboration with the Mental Health Foundation and is a key piece of research adding to the discourse on Muslim men's mental health. Though this is an under-researched area, Bobat's work provides important knowledge, both for those working in theories relating to Muslim men's mental health, but also gives practical advice to those working in the field. While Bobat gained his research participants from a South Asian mental health group in Manchester and specifically sought those suffering from mental ill health to interview, there are some parallels which may be able to be drawn from his study to this thesis. Overall, Bobat found that the mosque was 'the most important institution in Islam after the home and work' and

[152] William Affleck et al., "'If One Does Not Fulfil His Duties, He Must Not Be a Man': Masculinity, Mental Health and Resilience Amongst Sri Lankan Tamil Refugee Men in Canada," *Culture, Medicine, and Psychiatry* 42, no. 4 (December 1, 2018): 840–61, https://doi.org/10.1007/s11013-018-9592-9. 841.
[153] Lim et al., "The Attribution of Mental Health Problems to Jinn." 2.
[154] Ibid
[155] Jamilla Hekmoun et al., "Muslim Youth: What's The Issue?" (Muslim Youth Helpline, n.d.), accessed June 9, 2020. 14.
[156] Ibid
[157] Bobat, "A User-Led Research Project into Mosque."

provides a sense of peace to those who attend.[158] Though Bobat's study provides much-needed insight into Muslim men's mental health, the findings are relatively old, almost twenty years. Many of the prevailing attitudes could be considered outdated, or at the very least, things may have improved since the report was written. Bobat's research also focused on the benefits of the mosque and did not analyse whether there were any negative effects on mental health due to attending the mosque, such as an increased risk of community stigma.

According to Dr Khaki, a GP writing in the Independent, Muslim men are a "ticking time bomb" with their mental health, and their reluctancy to discuss their issues means they only seek help when it's almost too late. He notes that especially as the National Health Service (NHS) is overstretched, it is important for men to speak about their issues as a preventative measure, as early intervention for mental ill health can prevent worsening issues.[159] This idea of a reluctance to discuss one's mental health is explored later in this thesis with participants.

Male disproportionality

Suicide rates in the U.K., are higher in men than in women.[160] Though this work does not concentrate mainly on suicide, interviews examined participants' opinions on this issue as it is quantitively under-researched within the Muslim community, evidenced by the lack of statistics on the topic by institutions such as mental health charities and the NHS. There exist gaps when examining suicide in different religious communities; the data is not recorded, so does not exist. Therefore, I could not use my study as a comparative to wider statistics. Death by suicide is something that cannot be broken down into subsections of race, religion, or ethnicity as these are not provided on death certificates. Therefore, when discussing suicide amongst Muslims, anecdotal evidence is often the only kind that is available. Gearing and Alonzo noted that substantive research into suicidality within the Muslim community is limited.[161] Though some studies have concluded that the Islamic faith is linked with a lower suicide acceptability and prevalence rates, these studies generally look at Muslims as

[158] Ibid. 7.
[159] "Opinion: Muslim Men Face Pressure to Ignore Their Mental Health Problems – It Is Time to Stop the Denial," The Independent, June 15, 2019, https://www.independent.co.uk/voices/muslim-men-depression-mental-health-nationals-mens-health-week-a8960001.html.
[160] 'Suicides in Wales 2022', 2020.
[161] Robin Edward Gearing and Dana Alonzo, "Religion and Suicide: New Findings," *Journal of Religion and Health* 57, no. 6 (December 1, 2018): 2478–99, https://doi.org/10.1007/s10943-018-0629-8. 2488.

homogenous in their religious interpretation, ignoring the religious subgroups that occur.[162] Through the interview sample obtained, this thesis examines the religiosity and attitudes towards suicide of those from different Islamic backgrounds.

Some mental health conditions disproportionately affect men. One example of this is suicide. In the UK, while it is reported that more women experience suicidal thoughts according to 2018 statistics, three-quarters of deaths due to suicide were among men.[163] Wales had the second highest suicide rate (per 100,000 people) of all the countries that make up Great Britain. Overall, the suicide rate in the UK is increasing.[164] Skegg states in her research in the Lancet that "being male is an important risk factor for suicide".[165] It is currently impossible to know whether suicide rates vary by religion, as death certificates in the UK do not record religious data.[166]

It is difficult to ascertain suicide statistics for Muslim men in the UK. As mentioned previously, death certificates in the UK do not currently record religion, meaning we are unable to make definitive links between religious adherence/non-adherence or religious identification and death by suicide. A handful of studies over the past ten years have examined the relationship between importance of religion and suicide risk. Most of these have not found an association, while two found more suicide ideation among persons who gave low importance to religion.[167]

Though Islam prohibits suicide in any form, some scholars are of the opinion that those who take their own lives are not mentally sound, therefore they cannot be held responsible for their own actions and their actions could not necessarily be considered as sinful. Hankir et al., believes that this prohibition may provide a protective factor for Muslims against suicide.[168] However, with the suicide rates in the UK steadily increasing and mental health

[162] Ibid.
[163] "Suicides in the UK - Office for National Statistics," accessed February 9, 2021, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations.
[164] Ibid.
[165] Keren Skegg, "Self-Harm," *Lancet (London, England)* 366, no. 9495 (October 22, 2005): 1471–83, https://doi.org/10.1016/S0140-6736(05)67600-3. 1473.
[166] Birmingham City Council, "Civil Registration Records," accessed December 5, 2023, https://www.birmingham.gov.uk/info/50164/family_history_research/1558/civil_registration_records/4.
[167] Ryan E. Lawrence et al., "Religion as a Risk Factor for Suicide Attempt and Suicide Ideation Among Depressed Patients," *The Journal of Nervous and Mental Disease* 204, no. 11 (November 2016): 845–50, https://doi.org/10.1097/NMD.0000000000000484. 849.
[168] Ahmed Hankir, Frederick Carrick, and Rashid Zaman, 'Islam, Mental Health and Being a Muslim in the West', *Psychiatria Danubina* Suppl 27 (27 September 2015): 53–59, https://pubmed.ncbi.nlm.nih.gov/26417737/. 54.

conditions worsening and the lack of reliable statistics, we cannot ascertain for certain whether aspects of the Muslim faith may currently protect against suicide.

This section has given an overview of men's mental health, followed by a focus on Muslim men's mental health. The literature on Muslim men's mental health in the UK is so far largely limited to anecdotal research in online articles. The lack of in-depth studies means that this thesis provides a much-needed investigation in the field.

Mental Health and the Effects of the COVID-19 Pandemic

It would be difficult to complete a current thesis on mental health without mentioning the impact of the COVID-19 pandemic. The year 2020 saw a massive challenge for the mental health of millions, if not billions of people worldwide and which, at least in Britain, seems to disproportionately affect BAME communities. Since the British Muslim community is over 97% non-white (and approximately one out of every three people who identify as such are Muslim), it is no surprise that British Muslims were heavily impacted by COVID-19.[169],[170] It is not only the often-devastating symptoms of the disease itself that have had an effect, but the impact on the community's mental health through excessive bereavement, lockdown rules that discriminated against areas with a higher Muslim population, and restrictions placed the night before Eid, provoking outrage in addition to "deflation and disappointment." [171]

Mental health charities such as the Muslim Youth Helpline have seen a dramatic increase in calls relating to COVID-19, with an increase of 313% on the previous year (2020 compared to 2019).[172] According to the helpline, 10% of these calls have been related to suicide and suicidal thoughts as a result of the lockdown.[173]

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[169] Ali and Muslim Council of Britain, *British Muslims in Numbers*, 24.
[170] "Why Are More People from BAME Backgrounds Dying from Coronavirus?," *BBC News*, June 19, 2020, sec. UK, https://www.bbc.com/news/uk-52219070.
[171] Nazia Parveen, "'Singled out': Oldham's Muslim Community on Lockdown Controls," *The Guardian*, July 31, 2020, sec. UK news, https://www.theguardian.com/uk-news/2020/jul/31/singled-out-oldham-muslim-community-coronavirus-lockdown-controls-eid; 'Coronavirus: "The Spirit of Eid Has Gone but Celebrations Continue"', *BBC News*, 31 July 2020, sec. Leeds & West Yorkshire, https://www.bbc.com/news/uk-england-leeds-53606190.
[172] MYH, "Islamic Relief UK Support MYH as Calls Relating to Mental Health Rise to over 300% during Covid-19," muslimyouth, September 30, 2020, https://www.myh.org.uk/post/islamic-relief-uk-support-myh-as-calls-relating-to-mental-health-rise-to-over-300-during-covid-19.
[173] Ibid.

Not only have the primary medical effects of the COVID-19 pandemic drastically affected the British Muslim community, but the secondary effects have had an impact, too. These include factors such as socioeconomic issues. As mentioned previously, British Muslims are one of the most socioeconomically deprived groups in the country and the COVID-19 pandemic has had a marked effect on those who are unable to work or who are unemployed.

A further impact of the COVID-19 pandemic was the closure of mosques. As it is mandatory for men to attend the weekly *jummah*[174] prayer at the mosque and recommended for men to attend other prayers in congregation, many men missed this weekly sense of community and time with the imam which they were previously accustomed. As Meran and Mason stated in their study of Muslim faith leaders, imams are "actively encouraging British Muslim communities to overcome their aversion to mental health services", something which is especially important for men as they are less likely to seek help from services.[175] As Hanif notes, individuals find solace in the mosque, especially those who may be struggling with mental illness, attending 'twice, thrice, or even five times during a 24-hour period'.[176]

Recent research by the Mental Health Foundation has suggested that there is a marked impact on individuals' mental health as a result of social-distancing and economic impacts of the coronavirus.[177] The report also recognises that not all groups experienced these issues equally, and some groups are more disadvantaged in these aspects than others. Though there has been a wealth of resources produced to aid individuals in helping to combat poor mental well-being during the pandemic, they have not been wholly successful due to the massive impact of the virus. Owing to the unexpected nature of the pandemic, this thesis was not originally intending to cover the impact of the pandemic in the interviews, but as a by-product of the timeline in which it is produced, it would be a missed opportunity to not ask participants about this topic.

This section provided a brief overview of the impact of the COVID-19 pandemic on the mental health of Muslims in the UK. As the information from the pandemic is slowly being

[174] Jummah prayer is the weekly Friday prayer prayed in congregation. The prayer occurs in replacement of the *dhuhr* or midday prayer.
[175] Meran, "Muslim Faith Leaders." 38.
[176] Bobat, "A User-Led Research Project into Mosque," 7.
[177] "Mental Health in the COVID-19 Pandemic: Recommendations for Prevention," Mental Health Foundation, July 8, 2020, https://www.mentalhealth.org.uk/coronavirus/pandemic-recommendations-prevention.

gathered and more research is done, further conclusions will be able to be confirmed about the effects of the coronavirus.

Emerging Literature

The field of Muslim mental health is one which is gaining a lot of traction amongst researchers, academics, and the like, particularly post-pandemic where increasing focus was given to mental health, both generally and specifically amongst Muslims.

In 2023, the Woolf Institute in collaboration with the Centre for Mental Health produced a factsheet on Muslim mental health; collating the determinants, access, experience, and outcomes of the topic.[178] It examines the inequalities that many Muslims face in relation to mental health and reiterates why studies that focus on Muslim mental health are so important; to dissect the reasons behind the statistics and look qualitatively at experiences; and how factors like poverty and low employment rates may contribute to poor mental health. The inequalities within Muslims and mental health not only exist in terms of determinants but also when Muslims seek support. Looking at the statistics from those who sought NHS talking therapies during 2021-2022, only 2.6% of Muslims finished their course of treatment.[179] Comparatively, 18.4% of Christian patients and 38.9% of those reporting no religion finished their talking therapy treatment.[180] This suggests a disconnect between practitioners, particularly in the NHS, and patients of faith such as Muslims. This set of statistics do not discuss any gender disparities, so that factor could be an implementation taken on by the NHS in their data collection.

In the USA, the organisation Maristan has been established to, amongst other things, conduct research into mental and spiritual wellness amongst Muslims.[181] While the socio-economic and ethnic backgrounds of Muslims in the USA are different to those in the UK, there are parallels which exist and opportunities to learn from organisations such as this one. Similarly, Stanford Muslim and Mental Health & Islamic Psychology Lab (MMHIP)

[178] The Woolf Institute, "Fact Sheet: Muslim Mental Health," text/html, The Woolf Institute (The Woolf Institute, October 29, 2023), https://www.woolf.cam.ac.uk/, https://www.woolf.cam.ac.uk/whats-on/news/fact-sheet-muslim-mental-health.
[179] Ibid.
[180] Ibid.
[181] "Home," Maristan, accessed October 31, 2023, https://maristan.org.

conducted research specifically on Muslim mental health on university campuses. This then led to the Muslim Mental Health Initiative at UC Berkeley, where students are provided with appropriate mental health services.[182] It would be pertinent for such research initiatives to be established in England and Wales to support individuals in those locations, but also to review parallels between the countries.

Conclusion of the Literature Review

This chapter began by defining mental health and mental illness as used in this thesis, to ensure the two are not conflated, as they often are in general parlance. As covered, mental health is used to describe one's general state of wellbeing that can be characterised by low mood or high mood; and someone experiencing good mental health can cope with the normal stressors of everyday life. It is important to note that mental health can be thought of as being on a spectrum in which one can change their place each hour or each day or each week. This spectrum has positive mental health at one end, and negative mental health at the other.

The Literature Review chapter discussed the existing literature surrounding the main research question of: "What is the impact of Islam and Muslim identity on experiences of mental ill health among Muslim men in South Wales?". To do so, this chapter began with broader literature and got increasingly specific to fit the elements of the research question. To that end, the first topics that were covered were general mental health, followed by religion and spirituality. These topics were examined firstly separately, and then together; to see what impact one may have on the other. This chapter then looked at mental health in the Muslim community, determining the factors of influence and barriers to seeking support. It also examined the cultural and religious contexts that exist. This chapter gave a brief history of Muslims in Wales to show that Wales provides a unique context for this study, and that it plays an important role in shaping the identity of participants. It also introduces the topics of gender and masculinity and how these may relate to ideas of mental health and mental illness.

This chapter has provided a comprehensive overview of topics related to mental ill health amongst Muslim men. It has covered broader aspects such as mental health in general and

[182] "Muslim Mental Health Initiative (MMHI)," Maristan, accessed October 30, 2023, https://maristan.org/mmhi.

the Muslim community in Wales, as well as more specific information relating to the mental health of Muslim men. It has discussed the differences between cultural and religious viewpoints toward mental illness and examined concepts around djinn and the evil eye. I have argued that there exists a significant research gap surrounding the topics of Muslim men's mental health in south Wales; one which this thesis seeks to fill.

During the duration of this thesis, new literature has emerged on Muslim mental health, both in the fields of religion and health. Discussions and analyses of these new developments and their impact on the field have been covered here as well. Overall, the background context to this study, and why a study of this nature is needed, have been duly explored.

This is the first piece of research which specifically concentrates on the mental health of Muslim men in south Wales; a topic which will contribute to effective planning for mental health services in the area. It sits at the intersection of the studies of Religion, Mental Health, and Sociology, giving multidisciplinary research that can fit within many areas.

CHAPTER THREE - METHODOLOGY

Introduction

This chapter is reflexive in nature, considering that the research took place during the COVID-19 pandemic and amongst a population who, as discussed earlier, were markedly impacted by this crisis. The methodology is discussed in depth, covering the pre-interview religiosity scale and interview process in addition to the reliability and analysis of the study as a whole. First, the methodological approaches chosen will be outlined, along with my epistemological standpoint. It then provides an analysis of religiosity questionnaires and how they may be applicable to this thesis. Then, the interview process is examined, looking reflexively on my position as the researcher and how this may affect the study.

This study followed a qualitative approach containing two different data collection methods: a questionnaire and an interview. It relies on empirical research concentrating on the relationship between faith and mental health amongst Muslim men. This is due to the lack of previous studies to which it can be compared. Affleck, Glass, and Macdonald noted that women often make up the majority of respondents in health studies, citing a study which examined the gender bias within health research with varying methodologies.[183] The results of this study gives a plethora of reasons as to why men may be underrepresented in health studies. Health studies may lack concentration on men to make up for studies which historically focused on white males.[184] Suggestions were also made that the recruitment methods used may be more appealing to women, and therefore deter men from engaging in studies. A reason they note, which is applicable to my research context, is that a 'lack of emotional expression among male research participants' is not only a deterrent for men to take part in the studies; but also, when they do (perhaps reluctantly) their responses are limited.[185]

[183] William Affleck, KC Glass, and Mary Ellen Macdonald, "The Limitations of Language: Male Participants, Stoicism, and the Qualitative Research Interview," *American Journal of Men's Health* 7, no. 2 (March 1, 2013): 155–62, https://doi.org/10.1177/1557988312464038.156.
[184] Ibid.
[185] Ibid.

A purely qualitative approach was most appropriate for this research owing to the need to understand nuances when discussing mental health. Though the research included a pre-interview religiosity questionnaire, this quantitative method was used simply to ascertain any potential links between religiosity, background, and views and experiences of mental ill health.

Though there is a high use of quantitative methods in mental health research, as noted by Harper and Thompson, I did not approach this study wanting to use statistics or having it be a purely health-related study.[186] The added dimension of this study being a sociological study meant that a quantitative method did not fit.

As Harper and Thompson mentioned, qualitative methods are more uncommon in mental health research, though acceptance is increasing.[187] Therefore, although this study sits across multiple disciplines, and qualitative methods are more common in Sociological and Theological studies, it is also relevant and valid to all, including the Mental Health field.

Harper and Thompson mention the reliance in mental health research on laboratory experiments and questionnaires. Though a traditional questionnaire as a method may have garnered my study more participants, with a topic so vital and personal, it was important to me to be able to establish a connection beyond a piece of paper. In my opinion, this type of research needs more of a personal approach including appropriate debriefing and aftercare for participants. They note that "qualitative approaches enable understanding of experience and processes", and by allowing these types of questions, we can assess factors like the quality of mental health resources, and the importance of factors in treatment. [188]

Grounded Theory in Methodology

I chose to utilise Grounded Theory as a method for interpreting my data; producing a theory on Muslim men and mental health experiences which is grounded in research. Grounded Theory as a sociological method was developed by Glaser and Strauss in 1967. They put

[186] David Harper and Andrew R. Thompson, *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (West Sussex: Wiley-Blackwell, 2012). *Intro.*
[187] Ibid
[188] Ibid

forward that theories which have been developed through Grounded Theory, and therefore based on data, "can usually not be completely refuted by more data or replaced by another theory".[189] With research into mental health currently receiving more attention and funding, it is likely that further studies could be conducted on similar topics to mine. If we take Glaser and Strauss' point as true, then as research on Muslim men and mental health progresses, my study will still be as valuable and important as it is today. Grounded Theory is a prominent theoretical framework within the fields of Psychology and Social Science.[190]

The approach I am utilising for Grounded Theory is a Constructivist one. This means that the theories examined were constructed by myself, using the results from my participants. Another component of Constructivist Grounded Theory means that the researcher must be continuously reflexive regarding positionality and relationship to the research question and to the participants.[191] Constructivist Grounded Theory means that I have constructed experiences and meanings with participants; asking their opinions on these in relation to the fields of inquiry.[192] In this instance, asking participants how they interpret terms such as masculinity and what it means to be a Muslim man, rather than using other interpretations to study its impact on mental health.

There is a precedent of using Grounded Theory for studies which focus on mental health. Many studies have used this method and have been able to yield valid results in their studies. In Chapter 10, "Grounded Theory Methods for Mental Health Practitioners", in the book Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners, Tweed and Charmaz discuss the strategies involved in the collection of data and its analysis within Grounded Theory.[193] They note that the process of Grounded Theory involves the researcher using "a series of analytical and reflexive strategies to aid

[189] Barney G. Glaser and Anselm L. Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research*, 5. paperback print (New Brunswick: Aldine Transaction, 2010), 4.
[190] Jane Mills, Ann Bonner, and Karen Francis, "The Development of Constructivist Grounded Theory." *International Journal of Qualitative Methods 5*, no. 1, (2006): 25-35, https://doi.org/10.1177/160940690600500103. 31.; Ylona Chun Tie, Melanie Birks, and Karen Francis, "Grounded Theory Research: A Design Framework for Novice Researchers," *SAGE Open Medicine* 7 (January 2, 2019): 2050312118822927, https://doi.org/10.1177/2050312118822927. 1.
[191] Henrik Lindqvist and Camilla Forsberg, "Constructivist Grounded Theory and Educational Research: Constructing Theories about Teachers' Work When Analysing Relationships between Codes," *International Journal of Research & Method in Education* 0, no. 0 (July 5, 2022): 1–11, https://doi.org/10.1080/1743727X.2022.2095998. 201.
[192] Chun Tie, Birks, and Francis, "Grounded Theory Research." 2.
[193] Alison Tweed and Kathy Charmaz, "Grounded Theory Methods for Mental Health Practitioners," in *Qualitative Research Methods in Mental Health and Psychotherapy*, ed. David Harper and Andrew R. Thompson, 1st ed. (Wiley, 2011), 131–46, https://doi.org/10.1002/9781119973249.ch10. 132.

the process of developing theory".[194] Included in this are all methods of analyses, encompassing categories, data, codes and concepts, and the process of comparing them.[195] The suggestion by Tweed and Charmaz is to use the strategy of memo-writing as an "intermediate stage between data collection and write-up".[196] The process of memo-writing is one which I incorporated into my research project. I achieved this through the utilisation of notetaking in the form of a diary immediately following each piece of data collection, in this instance, after each interview. I was able to capture my considerations, contemplations, and immediate, basic analysis following each one. This also led me to be able to add or re-word certain questions, based on the reactions or responses of the earlier participants.

Theoretical codes emerge in the process of sorting the memos into a "potential substantive theory".[197] As Glaser noted, the authority of Grounded Theory applies when the researcher stays open to "the emergence of codes that fit with relevance when generating a Grounded Theory".[198] When Glaser discussed this, he meant that it was important for a researcher to be open to the "fullest possible array of theoretical codes", perhaps considering those which may not be obvious.[199] Glaser also discussed a challenge that often comes with many when dealing with Grounded Theory; a challenge which I also found. The challenge is that researchers who are used to more practical considerations of studies, may find it difficult "staying on the substantively abstract of conceptualization [sic]".[200] I found this difficult as one of the main aims with this research for me was to ensure a practical application of the results and recommendations of this study. However, I was able to combine the notions of practicalities with theoretical frameworks to produce a robust piece of research.

Tweed and Charmaz discussed the type of research questions to which the use of Grounded Theory is most suited. They state that the theory is most suited to 'open-ended research questions that focus on processes, patterns, and meaning within context and that require the crucial examination of subjectivity of experience'.[201] In consideration to my research question, it is one which is suited to Grounded Theory due to its inclusion of the study of

[194] Ibid.
[195] Ibid.
[196] Ibid.
[197] Barney G Glaser, 'Staying Open: The Use of Theoretical Codes in GT', *Grounded Theory Review* 12, no. 1 (2013), https://groundedtheoryreview.com/wp-content/uploads/2014/03/1201_01-1.pdf. 3.
[198] Ibid.
[199] Ibid, 4.
[200] Ibid, 3.
[201] Tweed and Charmaz, "Grounded Theory Methods for Mental Health Practitioners." 134.

personal experiences related to participants' understandings and familiarities of mental health.

Tweed and Charmaz note that, "the focus on social processes enables Grounded Theory to investigate how social structures, situations and relationships influence patterns of behaviour, interactions and interpretations. This focus can include the impact of policies and services upon behaviour".[202] Relating to my thesis, one focus with my research was to understand how social structures and an individual's social relationships or lack thereof may have impacted their mental health and providing policy and service recommendations as a result.

Another reason I chose to incorporate Grounded Theory into my work is because it fits with evolving ideas of "experts by experience". This is an idea becoming increasingly prevalent within mental health services, that those with lived experience should be able to contribute to the design of services, service policy, and inspection. For example, the Care Quality Commission, the UK regulatory body of many mental health and social care services, uses experts by experience to help conduct their inspections of said services.[203] Similarly, mental health organisations and charities also use Experts by Experience to improve their services and ensure those with lived experience are integral to producing care.[204] They can ensure that any negative occurrences that they had experienced throughout their care relating to their specific mental illness need, or religious or cultural background, would not happen in the future.[205]

The idea of Experts by Experience fits with Grounded Theory, as I enabled the experts – in this case the participants who are speaking about their own lives – to discuss what they felt was important within the bounds of the subject area, without imposing a preconceived theory upon them. Thus, this work can be used in areas such as improving mental health policy and services, because it utilises the method of Experts by Experience which is increasingly

[202] Ibid.
[203] "Experts by Experience - Care Quality Commission," accessed February 26, 2023, https://www.cqc.org.uk/about-us/jobs/experts-experience.
[204] "Experts by Experience Involvement Roles," Experts by Experience Involvement Roles, accessed November 28, 2023, https://www.rethink.org/aboutus/what-we-do/community-mental-health-unit/experts-by-experience-involvement-roles/.
[205] "Experts by Experience Are Invaluable in Mental Health: But How Exactly?," accessed November 28, 2023, https://www.mentalhealth.org.uk/explore-mental-health/blogs/experts-experience-are-invaluable-mental-health-how-exactly.

becoming the norm. Gradually, this idea is also becoming more popular in other areas such as in academia.[206]

Epistemologically, the relationship between researchers and participants is seen as subjective in a Constructivist position.[207] By acknowledging that researchers during the interview process are subjective, rather than objective, it allows for an increase in reflexivity regarding the researcher's opinions and positionality.[208] Throughout my research, I ruminated on my position as a researcher in relation to being a woman interviewing men, being someone who has lived experience of mental ill health (though this was not shared with participants, but it may have indirectly affected the way I engaged with them), and as someone who does not appear visibly Muslim as I do not wear the hijab. Therefore, the participants may have felt I was not a Muslim, and therefore more of an outsider interviewing them.

Arendell, in her article about women researching men, posited a question related to male dominance and misogyny, writing "an important and unavoidable question for those of us with feminist sensibilities. In serving as an "audience" to these men, as they asserted their beliefs in male superiority, expressed other kinds of sexist and misogynist sentiments, and described behaviors [sic] hostile to women, did I contribute to or even implicitly endorse the perpetuation of the system of male dominance?"[209] This is a question upon which I also speculated as a woman researching men. By not actively interrupting misogyny during an interview and not challenging these views, as expected of a researcher, this may have given participants the impression I agreed with them. I needed to stay objective as a researcher. This was especially at the forefront of my mind at the beginning of my interviews as they took place around the time of the Sarah Everard murder in 2021; a case which uncovered misogyny within UK police forces and prompted investigations.[210] Following this, I spoke with my supervisors and others and compartmentalised these concerns. While they were in my mind, it was important for me to think about how this may affect my research and

[206] Brenda Happell et al., "Creating or Taking Opportunity: Strategies for Implementing Expert by Experience Positions in Mental Health Academia," *Journal of Psychiatric and Mental Health Nursing* 29, no. 4 (2022): 592–602, https://doi.org/10.1111/jpm.12839.
[207] Mills, "The Development of Constructivist Grounded Theory," 26.
[208] Ibid.
[209] Terry Arendell, "Reflections on the Researcher-Researched Relationship: A Woman Interviewing Men," *Qualitative Sociology* 20, no. 3 (July 1, 1997): 341–68, https://doi.org/10.1023/A:1024727316052. 363.
[210] "Female Violence Investigation over 13 Gloucestershire Police Staff - BBC News," accessed February 26, 2023, https://www.bbc.co.uk/news/uk-politics-64762565; Chris Pollard, "Figures Reveal 1 in 100 Police Officers Faced Criminal Charges in 2022," Mail Online, February 25, 2023, https://www.dailymail.co.uk/news/article-11793547/Shock-figures-reveal-1-100-police-officers-faced-criminal-charges-2022.html.

interactions with participants in order to mitigate the impact. This reflexivity aids in building reliability, rigour, quality, and validity within my study.[211] Therefore, I reiterated the importance of my research to myself, understanding that this is an academic piece of work which will have an impact on many lives.

Furthermore, utilising semi-structured interviews meant I could stick to the topic at hand and should a participant express sexist or misogynistic views as noted by Arendell, I could steer them back to the intended topic while keeping within my methodological framework.[212] Though, if the conversation moved towards anything I could deem as offensive or felt that I was being personally attacked, I would have ended the interview so as not to have skewed my judgement of the process. I would have then consulted my supervisors or similar studies to seek advice on how to proceed, and whether to invite the individual back for another interview.

Theoretical Framework

In this thesis, I am utilising Durkheim's idea of functionalism. The idea that religion provides a function for its followers seemed the most apt, particularly when referencing Durkheim's view of religion. Durkheim viewed one of the functions of religion is to be part of a community, enmeshed in social relationships. He viewed "that the more extensive and denser a collective's social relationships – i.e., the more integrated the collective – the more enmeshed individual group members become, and, therefore, the more meaning and purpose individuals feel about their lives."[213] He believed that these relationships would serve as a protective factor for suicide and promote wellbeing amongst individuals. Durkheim wrote not only about religion, but also regarding mental health, particularly in relation to suicide. Durkheim saw suicide as a societal failure, and that a lack of personal or purposeful relationships led to individuals taking their own lives.[214] If we mesh Durkheim's view of religion as serving a functional purpose, specifically regarding community-building, with

[211] Supriya Subramani, "Practising Reflexivity: Ethics, Methodology and Theory Construction," *Methodological Innovations 12,* no.2 (July 2019), https://doi.org/10.1177/2059799119863276. 7.
[212] Arendell, "Reflections on the Researcher-Researched Relationship." 363.
[213] Anna S. Mueller et al., "The Social Roots of Suicide: Theorizing How the External Social World Matters to Suicide and Suicide Prevention," *Frontiers in Psychology* 12 (2021), https://www.frontiersin.org/articles/10.3389/fpsyg.2021.621569. 2.
[214] Ibid.

what he noted on the importance of community relationships in suicide prevention, we can theorise therefore the importance of religion to an individual in relation to their mental health.

In terms of my work, this was something I examined during interviews, with many participants commenting that their religious communities, often those surrounding their local areas or mosques, provided the function of a positive influence on their mental health. They felt the negative effects when covid ensued and they were unable to attend practices such as *jummah* prayers or mosque talks. Though this thesis did not explore suicide per se, Durkheim's idea of religion providing a protective factor for positive mental health, and the idea that community could promote this, is one which I have explored. It transfers Durkheim's idea into the 21st century and observes Muslims as opposed to the Christians he studied.

Durkheim believed that the changing of regulation, or the status quo, could be weakened by factors such as a collective crisis (such as a global pandemic). Through these weakened regulations, Durkheim posited that there would be increase causation of suicide.[215] This can be mirrored in my research, not specifically in regard to suicide, but the global COVID-19 which worsened many participants' mental health, as seen in the interview section of this thesis.

Durkheim's work does have some limitations. He theorised in the late 1800s/early 1900s and was based in France. It is important to acknowledge the context in which he arrived at these theories, as he was writing in a predominantly white, Christian setting, and this thesis examines Muslims, mainly from ethnic minority backgrounds, living in a mainly white but still more ethnically diverse, society. Despite these drawbacks, Durkheim's theories were used to address the epistemological concerns of this thesis. While other theorists were considered, Durkheim's ideas holistically fit more appropriately with my thesis. I had considered utilising the work of Freud, as this thesis discusses mental health, and he is one of the foremost thinkers in the field of Western Psychology. However, Freud's opinion that religion is a form of narcissism is not appropriate in this case, as I was interviewing individuals who considered themselves as followers of a religion. In his book The Future of an Illusion, Freud said of religious doctrines "we can now repeat that all of them are

[215] Ibid, 3.

illusions", and that "some of them are so improbable, so incompatible with everything we have laboriously discovered about the reality of the world, that we may compare them – if we pay proper regard to the psychological differences – to delusions."[216] I find Freud's opinions as a toxic contrast to Durkheim's respect for religion as a tool to improve lives through function. Furthermore, it would be inappropriate in a thesis about mental health and religion to incorporate the work of a theorist who believes that religion in and of itself is a kind of mental illness to humans, the "universal obsessional neurosis of humanity".[217]

My reasons for choosing Durkheim were that his theories fit within the context of this thesis. Comparatively, other theorists' work seem to be more appropriate for the times and religions they were writing about. While I considered these theories, I did not utilise them for this thesis. Furthermore, Durkheim's work on suicide were the only points he made regarding mental health and mental illness. As not all individuals who suffer with mental ill health have experience of suicide, we cannot say that his ideas on suicide prevention will also work for preventing other conditions or symptoms of mental ill health. However, his ideas of religion as a function and the role of the community are still extremely important and useful, and ideas which many participants mentioned as contributing to their positive mental health.

Another key theorist whose work I considered is that of Karl Marx, as he wrote about religion as a form of social control. Marx once described religion as the "opium of the people", and stated, "religion is the sign of the oppressed creature, the heart of a heartless world and the soul of soulless [sic] conditions."[218] His ideas of religion were tied into his ideas of communism; that if workers' religion was taken away, they would refocus on their working conditions and be motivated to change them. Marx was mainly concerned with how religion and the economy played into each other, after all, according to Max Weber, capitalism flourished as a result of Protestants' work ethic. Marx's assertion that religion is a narcotic, suggests religion remains "an illusory amelioration for a situation of despair"[219]. He felt that religion was for those who needed sedation from their lives, and more esoteric than rational. I did not feel that Marx's approach to religion was appropriate for this study, as it does not

[216] Sigmund Freud, *The Future of an Illusion*, trans. James Strachey (New York: WW Norton and Company, 1961). 31.
[217] Ibid, 43.
[218] Karl Marx, *Critique of Hegel's "Philosophy of Right"* (Cambridge University Press, 1970). 131.
[219] J. Luchte, "Marx and the Sacred," *Journal of Church and State* 51, no. 3 (June 1, 2009): 413–37, https://doi.org/10.1093/jcs/csp095. 413.

suggest religion as a force for good. This is opposed to what many studies on Muslim mental health, and mental health more generally have felt about religion. Marx almost comes across as sympathetic, yet patronising to followers of religions at time, referring to it as an "illusory happiness", something that provides individuals with deceptions so they may carry on with their lives.[220]

Marx's opium analogy was further elaborated on by Lenin in which he said, "Religion is opium for the people. Religion is a sort of spiritual booze, in which the slaves of capital drown their human image, their demand for a life more or less worthy of man."[221] The lengthier quote reiterates the communist values of both figures, emphasised by referring to individuals as "slaves of capital". Pedersen argues that Marx's critique of religion was much subtler than Lenin's; however, with the latter's use of "for the people" implies that capitalists are the ones who are giving the opium.[222] She argues that imagery around opium at the time these theorists were writing was frequently connected to religion and that this understanding further helps to explain Marx's views on the subject.[223]

Another key sociologist who wrote about religion, but whose approach I did not choose is Max Weber. Not only did Weber credit religion for the rising and spread of capitalism, but he also understood religion through theodicy.[224] Theodicy, as understood by Weber, is the idea that if there is the "conception of a transcendental unitary god who is universal, the more there arises the problem of how extraordinary power of such a god can be reconciled with the imperfection of the world".[225] To put it plainly, theodicy is about the vindication of God, why God would allow evil in the world if He is all-powerful. In this instance, I did not utilise Weber's approaches to religion as I felt they could less be applied to understandings of Muslim mental health than other theories. None of the participants interviewed spoke about God or Allah as someone who is vindictive, whether in relation to mental health experiences or generally. Within Islam there is a belief in the idea of destiny or that God or

[220] Karl Marx, 'Marx, A Contribution to the Critique of Hegel's Philosophy of Right 1844', 1844 1843, https://www.marxists.org/archive/marx/works/1843/critique-hpr/intro.htm#05.
[221] Esther Oluffa Pedersen, "Religion Is the Opium of the People: An Investigation into the Intellectual Context of Marx's Critique of Religion," *History of Political Thought* 36, no. 2 (2015): 354–87, https://www.jstor.org/stable/26228603. 355.
[222] Ibid.
[223] Ibid, 357.
[224] "The Problem of Suffering and the Sociological Task of Theodicy," accessed October 31, 2023, https://doi.org/10.1177/13684310122225073. 200.
[225] Max Weber, *The Sociology of Religion*, trans. Ephraim Fischoff (London: Methuen & Co London, 1965). 139.

Allah has a plan for all, and so all events that happen, whether good or bad, are part of a larger plan.

Weber, similar to most theorists of his time, concentrated Judaism and Christianity, but not Islam. He spoke briefly on what he referred to as "Eastern religions", but these were mainly non-theistic or polytheistic religions. Islam, however, has more in common with Judeo-Christian traditions. Weber's take on religion is quite wide; looking at whether political changes have an effect on the religion of the masses as one such example. Contrary to my study, where I am examining more personal approaches to religion and the effects it may have on an individual's life, this may be particularly in relation to their relationships, social life, and community life.

Thinkers such as Durkheim and Weber asserted a "nonreligious positionality" from which they viewed and conducted their work, and subsequent scholars categorised them as "secular".[226] This interpretation ignores the contextual backgrounds and biases that come with anyone, even if they believe they are disassociated from religion, or religious-cultural practices. Horii argues that despite Durkheim and Weber's aims to categorise themselves amongst a "religious-secular distinction", their works exist within and are intertwined with the country in which they live.[227] In the framing of this dissertation, I have acknowledged the contextual background and frameworks which exist and may contribute to any biases surrounding this work. Similarly, I have acknowledged the circumstances in which theorists such as Durkheim, Weber, Marx, and later, Said, have developed their theories, and how this may have influenced the theories themselves.

In light of these theories, I believe Durkheim's ideas of functionalism best encompassed how the participants I interviewed felt about religion and how religion impacted them, whether positively or negatively. Within Islam, there is a great emphasis put on the Muslim *ummah*, and this idea strengthens Durkheim's view of the community as a religious function. In the Qur'an, the ummah is generally defined as a community, but with different variations. Surah Hud, verse 118 says:

[226] Mitsutoshi Horii, "Historicizing the Category of 'Religion' in Sociological Theories: Max Weber and Emile Durkheim," *Critical Research on Religion* 7, no. 1 (April 1, 2019): 24–37, https://doi.org/10.1177/2050303218800369. 26.
[227] Ibid.

> "If your Lord had pleased, He would have made all people a single community, but they continue to have their differences".[228]

Here, the word ummah is translated as "community", and "*ummah waḥida*" as a single community.

Surah al Naḥl, verse 120 says:

> "Abraham was truly an example: devoutly obedient to God and true in faith. He was not an idolater."[229]

Here, the word ummah is translated as "an example", meaning a positive example of a leader. This definition is one which is less commonly ascribed to when speaking about an ummah in general parlance. Generally, the term "ummah" or "Muslim ummah" 'usually refers to human community in a religious sense, to 'ethnical, linguistic or religious bodies of people who are objects of the divine plan of salvation.'[230]

If we ascribe to the idea that religion is about providing a function, then the function for my participants is that it fulfils a social role in terms of the community aspect, but also a spiritual role in the belief that there is something greater than oneself. The latter perhaps could be linked to Marx's idea of religion as opium if you can consider opium in the terms of peace rather than sedation. While this interpretation is interesting to try and ascribe Marx to a positive view of religion, Durkheim's theory fits better with my participants. The theory chosen may have differed had I been examining Muslims living in a Muslim country, where perhaps there would be less of a need for established communities enclave communities or intentional community building, as Islam there would be the norm. For that, a different epistemological concern may have been valid, but I believe Durkheim's ideas fit the best here.

[228] Abdel Haleem, *The Qur'an*. 144.
[229] Ibid, 174.
[230] 'The Meaning of "Ummah" in the Qurʾān', accessed 29 January 2024, https://doi.org/10.1086/462733. 34.

Orientalism

Orientalism, in its narrative form, is a term coined by Edward Said in his 1978 book of the same name. Said's view of the Orient is that it has 'helped define Europe (or the West) as its contrasting image, idea, personality, and experience.'[231] Sociologically, Orientalism refers to 'a style of thought based upon an ontological and epistemological distinction made between "the Orient" and (most of the time) the Occident.'[232] He further defined Orientalism as a 'Western style for dominating, restructuring, and having authority over the orient.'[233] Orientalism has an impact on what is said about the Orient, and the people, religions, and customs within it. Said noted that 'The relationship between the Occident and the Orient is a relationship of power, of domination, of varying degrees of complex hegemony.'[234] Thus, through Orientalism, the West (the Occident) has dominance over the East (the Orient). This dominance can be expressed implicitly or explicitly. Orientalism can be shown not only through power dynamics between East and West, or negativity and inferiority of the Orient by the Occident, but in how the latter often fetishizes and romanticises the East in a way that enables it to look on with perverse intrigue.[235] Both ideas portray the East/Orient in a way that is the *other*, something different but still inferior to the Occident, and whose purpose is either to have power over, or to fetishize.

When observing Orientalism as it may relate to British Muslims, we can examine both media portrayals and policy-making that relegates Muslims to an Oriental *other* who is considered inferior.[236] We have observed this particularly in the post-9/11 world. Western media has often been criticised for its Orientalist narratives it often portrays.[237] This criticism often occurs when the media covers topics relating to the Orient, such as wars in the Middle East but also positive events such as the FIFA World Cup hosted in Qatar.[238] This also occurs

[231] Edward W. Said, *Orientalism* (New York: Random House, 1978), 1.
[232] Ibid, 2,3.
[233] Ibid, 3.
[234] Ibid, 5.
[235] Damir Skenderovic and Christina Späti, "From Orientalism to Islamophobia: Reflections, Confirmations, and Reservations," *ReOrient* 4, no. 2 (2019): 130–43, https://doi.org/10.13169/reorient.4.2.0130. 132.
[236] Cristina Algaba Cimini Beatriz Tomé-Alonso, Giulia, "Orientalism and the Mass Media—a Study of the Representation of Muslims in Southern European TV Fiction: The Case of Spanish Prime-Time TV Series," in *Hate Speech and Polarization in Participatory Society* (Routledge, 2021). 221
[237] "Traces of Orientalism in Media Studies," accessed October 31, 2023, https://doi.org/10.1177/01634437211022692. 1137.
[238] Marc Owen Jones, "UK Press Coverage of Qatar 2022: Hypocrisy and Orientalism," https://www.newarab.com/ (The New Arab, November 1, 2022), https://www.newarab.com/opinion/uk-press-coverage-qatar-2022-hypocrisy-and-orientalism.

closer to home when covering Muslims in the UK in addition to ethnic minorities in the UK more generally. We can see this in some of the policies that occurred during the COVID pandemic. For example, when the night before Eid al-Adha in 2020, parts of the North-West of England were put back into lockdown.[239] These areas contain large Muslim populations and meant Eid celebrations could not go on. Many in the affected communities felt that this was specifically targeted towards Muslims as they were seen as 'not taking the pandemic seriously enough', a claim rooted in Islamophobia, racism, and untruths.[240] This Orientalist narrative had a profound effect on the mental health of those that the policy impacted.

The link between Orientalism and Muslim mental health may not be obvious, but it does exist. In this instance, Muslims in Britain are the representation of the Orient. We can see this through policies which may shape social determinants such as poverty, employment, or housing inequalities. Though these policies would not explicitly target Muslims, they may do so implicitly. Taking Said's view through Orientalism, one could interpret this is likely a subconscious process that marks these people as lesser or more dangerous. Social determinants then control the access Muslims may have to mental health services. Orientalism may also present when practitioners interact with their clients, with the former taking an Orientalist view of the latter's cultural and religious background. Practitioners may hold Orientalist views, particularly around Muslim men, for example that they oppress women. Orientalism is a form of racism that is often subversive and mainly within our assumptions of the *other*. This leads to Muslims having a negative experience of mental health services and places a greater emphasis on finding culturally appropriate and religiously literate services for Muslims in the UK, with practitioners that can identify and discard Orientalist views, in addition to seeing faith and religion in a way that it can positively impact mental health recovery.

Practitioners who follow Channel and Prevent Multi-Agency Panel (PMAP) Guidance may also be impacted.[241] Channel and PMAP fall under the umbrella of the Prevent strategy; an approach which the government feels protects people who may be susceptible to

[239] Aina J. Khan, "Amid the Sorrow over Cancelled Eid Plans, British Muslims Should Feel Let down Too," *The Guardian*, July 31, 2020, sec. Opinion, https://www.theguardian.com/commentisfree/2020/jul/31/eid-cancelled-british-muslims-bame-covid.
[240] "Muslim and BAME Communities Not Taking Coronavirus Pandemic Seriously, Tory MP Says," LBC, accessed November 1, 2023, https://www.lbc.co.uk/radio/presenters/ian-payne/muslim-bame-communities-coronavirus-pandemic/.
[241] "Channel and Prevent Multi-Agency Panel (PMAP) Guidance," GOV.UK, October 9, 2023, https://www.gov.uk/government/publications/channel-and-prevent-multi-agency-panel-pmap-guidance.

radicalisation. From this, the onus is put onto professions such as teachers, doctors, and counsellors to spot the signs of radicalisation in their clients or pupils and refer them to the programme. In 2016, the Royal College of Psychiatrists published a statement on counter terrorism and psychiatry. This document detailed how to work with the Prevent strategy while simultaneously providing appropriate care. The document recognises the issues between those, particularly young people, who may be referred to Channel and Prevent, and how this may be because of their presentation of mental health issues. The document says:

> *"*There is very probably an overlap between those who are, or ought to be, seen in CAMHS [Child and Adolescent Mental Health Services] or young adult services, and those seen by the Channel programme. It is therefore important that the commitments made to improve mental health services for troubled adolescents and young people are honoured. This will have tangible benefits for mental health, might contribute to reducing the risk of lone-actor violence, and might also help to reduce some of the suspicions that exist about the Prevent agenda. It might also reduce the possibility of unintended consequences of inappropriately labelling already troubled young people and adding to their sense of alienation and victimisation."[242]

Despite the assertions by the RCPH and other organisations, many Muslims have been referred to Prevent for issues unrelated to terrorism or terrorist activity. For example, going to Hajj, attending A&E with burns, or watching Arabic TV.[243] Incidents such as these may preclude Muslims from seeking mental health support or engaging with medical professionals to avoid being wrongly referred to counter-terrorism services. This is an example of Orientalism in action.

Younis and Jadhav noted that, "Prevent engages in performative colour-blindness–the active recognition and dismissal of the raceframe which associates racialised Muslims with the threat of terrorism."[244] In this instance, they described "race" as "fundamentally related to power", where "Whiteness is seen as the norm", and therefore in power.[245] Race frame in this article is described as 'As all social relations are subject to power, so too is racial hierarchy embedded within the logic of all social interactions–this is the race frame.'[246] This

[242] Royal College of Psychiatry, "Counter Terrorism and Psychiatry" (Royal College of Psychiatrists), accessed October 31, 2023, https://www.rcpsych.ac.uk/pdf/PS04_16.pdf.
[243] Diane Taylor, "Report Finds Some NHS Mental Health Trusts Screen All Patients for Radicalisation," *The Guardian*, March 19, 2018, sec. UK news, https://www.theguardian.com/uk-news/2018/mar/19/report-finds-some-nhs-mental-health-trusts-screening-all-patients-for-radicalisation-prevent.
[244] Tarek Younis and Sushrut Jadhav, "Islamophobia in the National Health Service: An Ethnography of Institutional Racism in PREVENT's Counter-Radicalisation Policy," *Sociology of Health & Illness* 42, no. 3 (2020): 610–26, https://doi.org/10.1111/1467-9566.13047. Abstract.
[245] Ibid, 612.
[246] Ibid.

description is related to the definition and by-product of Orientalism mentioned in this thesis; particularly regarding the issues around racial hierarchy and power.

The issue of internalising the Orientalist narrative may also be present in Muslim mental health. If one sees themselves as the O*ther*, or feels that they are being O*thered,* this may have a detrimental effect on their mental health. This may also prevent Muslims from seeking support for their mental health, as they believe these negative experiences are their own fault. Similarly, they may adopt the same attitudes, even when detrimental to themselves. This has been evidenced through studies of internalised racism. Through examining existing literature, Gale et al., investigated the relationship between 'Internalized Racial Oppression and Health-Related Outcomes,' finding that internalised racism was 'significantly related to mental and physical health outcomes.'[247] In this study, it was found that internalised racism had a correlation with both negative physical and mental health.[248] This may be mirrored in the context of Muslim mental health in the U.K.

The Orientalist portrayal of Muslim men in the West is also a factor which may contribute to detrimental mental health, and a lessening desire to seek support. Through media and film, Muslim men are often stereotyped, and these stereotypes have infiltrated public perceptions and opinions on Muslim men.[249] These stereotypes are often prevalent in the media, featuring in stories which may contain false statements or hyperbole about Muslim men.[250] This has been seen frequently during the 2023/2024 Gaza war, where Muslim, Arab men have been often portrayed as violent.[251] In Said's work, Covering Islam, he notes the media and academic portrayals of Muslims as "oil suppliers, as terrorists, and more recently, as bloodthirsty mobs".[252] Said described these portrayals as "crude, essentialised caricatures," which are perpetuated even by individuals who report on Muslims.[253]

[247] Michael M. Gale et al., 'A Meta-Analysis of the Relationship Between Internalized Racial Oppression and Health-Related Outcomes', *The Counseling Psychologist* 48, no. 4 (1 May 2020): 498–525, https://doi.org/10.1177/0011000020904454. 515.
[248] Ibid.
[249] 'UK Media's Portrayal of Muslims "Misleading and Negative": Study', Al Jazeera, accessed 27 January 2024, https://www.aljazeera.com/news/2019/7/9/uk-medias-portrayal-of-muslims-misleading-and-negative-study.
[250] Faisal Hanif, "State of Media Reporting on Islam & Muslims" (Centre of Media Monitoring, Muslim Council of Britain, 2019).
[251] Khaled Beydoun, 'Demonising Palestinian Men — Terrorists until Proven Otherwise', DAWN.COM, 12:15:51+05:00, https://www.dawn.com/news/1796941.
[252] Edward W. Said, *Covering Islam* (New York: Vintage Books, 1981). 6.
[253] Ibid, 28.

Criticisms of Orientalism exist, and it is important to cover them for this thesis. Some critics, after Orientalism's release, dubbed Said "Professor of Terror", and as a "mouthpiece for Palestinian terrorists".[254] One prominent critic Orientalism and Edward Said is Bernard Lewis. Lewis, a controversial figure, referred to the post-colonial term of 'Orientalist' being 'polluted beyond salvation', and that the word had "lost its value."[255] Lewis criticises many of Said's points made in Orientalism and mentions that Said's version of the Orient is "reduced to the Middle East," and removes Turkish, Persian and Semitic studies.[256] However, though Said may have focussed primarily on Arabs and the Middle East, many scholars have used his theories to apply to modern-day relationships between the East and West, or the Global South and the Global North. It is difficult to give merit to critiques when notions of Orientalism are still aptly applied to situations in the present-day. Halliday has criticisms of both Said's and Lewis' works. However, these criticisms are mainly to do with perceptions of studying the Middle East.[257]

Approaches to Religion and Mental Health

To first measure religiosity, one must find an appropriate definition of religion. We also must discuss how modern and historic psychologists and sociologists have approached the study of religion, and how religion and mental health could or could not integrate. Most theorists in the Western world have developed their ideas based on a predominantly Judeo-Christian point of view. The theorists regarded as essential in Sociology were not writing in the 21st century, and not usually from a context of a minority religion in a country with a majority other religion. Therefore, it can be hard to apply some of their theories into a modern, British Muslim context. To find theorists suitable for this study, it is important to examine the intersectional lines upon which this thesis sits. For example, the intersection between Psychology and Sociology, or the intersection between mental health and religion. However, this thesis takes a Sociological approach to these other disciplines.

[254] Pankaj Mishra, 'The Reorientations of Edward Said', *The New Yorker*, 19 April 2021, https://www.newyorker.com/magazine/2021/04/26/the-reorientations-of-edward-said.
[255] Andrew Dole, 'The Question of Orientalism by Bernard Lewis | The New York Review of Books', *The New York Review of Books*, n.d. 4.
[256] Ibid, 9.
[257] Fred Halliday, '"Orientalism" and Its Critics', *British Journal of Middle Eastern Studies* 20, no. 2 (1993): 145–63, https://www.jstor.org/stable/195877. 145.

Allport, writing in 1951, noted that the majority of psychologists who have remarked on religion agree "that there is no single and unique religious emotion, but rather a widely divergent set of experiences".[258] This is why it can be difficult to measure religiosity; as researchers must understand that it's a fluid concept, susceptible to change and often not definable across all followers. Allport understood that variation existed within religion, and within mental life patterns, and this thought could help the individual with their own mental health. He stressed the importance of "Love" as the greatest psychotherapeutic agent, and that religion was the place in which one may find love.[259] Relating this to my study, the concept of "love" is that which could be found in the community, showing the importance of community help in mental health, and perhaps love being a protective factor towards mental ill health. Allport also spoke about potential negative effects religion may have on mental health, mentioning scrupulosity. Inherently, he noted, religion is good, but when an individual becomes obsessive, it can become detrimental.[260] This can be observed within the Muslim community through scrupulosity or religious OCD, with behaviours such as repeated ablutions (wudu), or avoiding eating outside one's home for fear of ingesting something haram.[261]

Glock and Stark, writing in 1966, discuss the nuances within individuality that can be looked at with different dimensions of value. These are: ideological, ritualistic, intellectual, consequential, experiential. My brief religiosity scale examines three of these dimensions, namely: ideological, ritualistic, and intellectual. As Glock and Stark note, there are only a few limited pieces of research which examine all dimensions simultaneously. As my religiosity scale/questionnaire does not form the basis of my main research goal, I chose to concentrate on the dimensions most relevant to Muslims in Britain today. Similarly, Glock and Stark examined these dimensions from a Western, Judeo-Christian approach in the 1960s, not all of which can be applied to 21st century British Muslims. They state that several studies they cited 'suggest that being religious on one dimension does not necessarily imply religiosity on other dimensions', thereby making it difficult to examine each independently of one another.[262] However, by utilising three of these dimensions together as in this thesis, it can give a useful generalised measure of religiosity for my study.

[258] Gordon W. Allport, *The Individual and His Religion* (London: Constable Publishers, 1951). 5.
[259] Ibid, 89
[260] Ibid, 92
[261] "International OCD Foundation | Islam and OCD."
[262] Charles Y. Glock and Rodney Stark, *Religion and Society in Tension* (U.S.A.: Rand McNally & Company, 1965), 22.

Glock and Stark also discuss how religion may relate to social integration within societies. Though they refer to religion as threatening social integration as much as it may contribute to it, they determine this due to the increasing secularisation in the United States in the 1960s.[263] In 21st century Britain, it may contribute to feelings of disintegration or perpetuate the trope that other religions, and Muslims especially, are unwilling to integrate with wider society.[264] This is a stereotype which is often reiterated by right-wing politicians to further justify their positions on policies such as immigration.

However, Abu Raiya gave a broader view of religion, through his analysis of many different scholars, stating 'people practice religion in different ways, connected to their thoughts, emotions, actions and relationships. Religion can be individualistic as well as collectivistic and provides various pathways to various destinations.'[265] From this, one can assume that even scholars of religion are not in agreement about the one way in which religion is practised and how it may impact on daily lives. Religion, therefore, is up to personal interpretation, in addition to religious doctrine which determines who is and is not a part of the faith. Likewise, if this is how individuals practise religion – in different ways – then this means that the purpose that religion serves can be different to different individuals.

Scales of Religiosity and their Implementation

There have been many attempts to measure the rate of an individual's religiousness or spirituality. It is a difficult task, as religion and spirituality are intrinsically personal. Though many religions have outward displays of perceived religiosity, for example amongst Muslims, actions such as wearing a hijab, not drinking alcohol, and sporting a beard. This section examines some of the attempts to measure religiosity by previous scholars and describes how and why they may have informed my own scales.

[263] Ibid, 171
[264] Al Jazeera, "'Integration for us is integration for everyone,' UK Muslims say," *Al Jazeera*, March 14, 2018, https://www.aljazeera.com/news/2018/3/14/integration-for-us-is-integration-for-everyone-uk-muslims-say.
[265] Hisham Abu Raiya et al., "A Psychological Measure of Islamic Religiousness: Development and Evidence for Reliability and Validity," *The International Journal for the Psychology of Religion* 18, no. 4 (November 10, 2008): 291–315, https://doi.org/10.1080/10508610802229270, 10.

Many scales to assess religiosity, particularly in Religion and Mental Health studies, examine religious coping inherently within the scale. However, I wanted to make these different because I do not think that level of coping ability is something that can fit neatly into a box, or necessarily that can be written down. It is information which is personal to the interviewee, so I wanted to give them the appropriate opportunity to discuss in the detail they felt comfortable with. Many scales that I found have been concentrated on Muslims in countries with high Muslim populations such as Iran, Malaysia, and Nigeria. These scales have biases with their cultural backgrounds, and as they were not conducted in the U.K., they would not be directly appropriate for this study.

Abu Raiya, in his 2008 thesis on measuring Islamic religiousness, provides an overview and analysis of existing religiosity scales and their impacts on participants in the studies.[266] Whilst commenting on a definition of religion devised by Pargament in 2002 which excluded 'concerns about the nature of the sacred that have little to do with significant human issues', he noted that such perspectives are more appropriate for studies into mental health.[267] Therefore, when applying this to devising religiosity questionnaires, one would keep the human and the sacred elements separate. This is a valued perspective, though it does beg the question of how mental health issues which may be tied to religion, such as scrupulosity, could be seen. Though this thesis is a qualitative one, I am measuring religiosity in order to provide background and intersectionality to answers.

Abu Raiya argues that there is an 'absence of empirical research about Islamic religiousness,' and this may be because of the lack of a 'valid and reliable psychological scale.'[268] Many studies looking at religion and mental health have merged scales together, looking at the two topics holistically as one when assessing religiosity.[269] By doing this however, one draws many assumptions about the individuals they are studying. Additionally, it draws very basic conclusions based on participants' answers. For example, more adherence to a belief is shown through the amount of practise someone does, for example, in terms of prayer and/or fasting. In the MARS scale by Wilde and Joseph, they discussed three factors that were used to assess religiosity, but they used questions and statements such

[266] Ibid.
[267] Ibid, 3.
[268] Ibid, 18.
[269] In this instance, RCOPE, MARS, and MUDRAS.

as, ‘I find it inspiring to read the Qur’an.’ I do not think one can necessarily make a judgement of religiosity, positive or negative coping mechanisms, or mental health based on answers to these questions. These answers do not give the interviewee to provide a wider context; something which is important when examining mental health. Therefore, in my study I wanted to ensure I was giving participants the opportunity to discuss and provide background information where possible.

Within Abu Raiya’s study, he came to many conclusions about what may be important to measure when assessing an individual’s religiosity. One of these factors was an individual’s ethical conduct, such as adhering to a halal diet and not having sexual relations outside marriage. I incorporated aspects of his study into my religiosity questions but omitted those I did not find appropriate. Within my work, I did ask individuals whether they keep a halal diet – broadly, abstaining from pork or alcohol, as the majority of scholarly opinions would agree that those are inherent to Islamic beliefs. However, I did not feel comfortable asking participants whether they partook in pre-marital sex, as I did not want participants to feel uncomfortable, nor did I find it prudent to include. My study was not one on religiosity scales explicitly, though it did include one, so I sought to only include questions covering the basics; mainly based on the five pillars of Islam. I assessed these questions mentioned by Abu Raiya against those offered by Muslim matrimonial sites, who, in their religiosity questions, ask about diet but not about sexual ethics endeavours. I did not want to ask participants about how their sex lives may relate to their mental health for two reasons. Firstly, I did not believe it to be wholly relevant for the aims and objectives of this study. Furthermore, literature and my study both found that it is difficult to engage men in mental health studies, so I did not want to potentially alienate any participants by discussing an issue which is often seen as taboo.

Some scales, such as that by Masri and Priester, go into excessive detail and develop connections between religiosity and factors such as wearing perfume and smoking cigarettes. In my opinion, these are not measures of religion to many modern-day Muslims, especially as there is often more meaning found in one’s prayer or fasting. The scale developed by Albelaikhi also goes into excessive detail, asking questions around topics like ‘Looking at a non-relative woman.’[270] For the purpose of this thesis, it would not be appropriate to define religion on these bases. Alternatively, this thesis will base its religiosity scale on the core

[270] Abdulaziz Albelaikhi, “Development of a Muslim Religiosity Scale” (PhD diss., University of Rhode Island, 1997), https://doi.org/10.23860/diss-albelaikhi-abdulaziz-1997.143.

beliefs of Islam; the five pillars, namely, Shahadah (declaration of faith), Prayer, Fasting, Hajj and Zakat. Koenig notes that having faith 'may not be as important as *what* a person believes', and whether they view God as a merciful or punitive has much more of an effect on health than the specific religion they follow.[271] Therefore, one factor that my religiosity scale will examine is how an individual views God, whether as a punishing or merciful being. Lawrence et al.'s study on religious ideation and suicide risk found an indicator of "negative religious coping", which is defined by an individual who may defer all their responsibility to God and experiencing conflicts or a struggle with God.[272]

A further method of a religiosity scale which has been developed is that which centres on religious coping. Pargament has been a leading scholar on this topic, and his scale developed with other researchers is commonly referred to as the Religious Coping Methods (RCOPE). While the RCOPE is useful and helps with my scale, the scale itself is not how I'm looking at religious coping. As religious coping is only one part of my study, I am seeking those answers from the qualitative interview aspects and not the religiosity scale/questionnaire in itself. [273] Pargament et al., suggest that the scales measuring religious coping are more beneficial for looking at outcomes related to health.[274] Though I appreciate this method may be appropriate for other mental health studies, as I am not examining the mental health progression of my participants, a broader religiosity questionnaire was required.

Self-identification as a follower of a particular religion was the most important factor for me when determining religiosity. Reflexively, this choice may be impacted by my personal perspective. My potential biases are explored later in this thesis within the Reflexivity section. By virtue of my participants taking part in my research, they consider themselves Muslim and therefore would espouse certain beliefs, for example belief in Allah and the prophet Muhammad. One participant identified himself as part of a denomination which many would not regard as being under the banner of Islam. Ahmadiyya Muslims are often considered by many as not Muslim, as the denomination was founded in the late 1800s by an individual claiming to be the *Mahdi.*[275] They also believe that the Prophet Muhammad

[271] Koenig, McCullough, and Larson, *Handbook of Religion and Health*. 70.
[272] Lawrence et al., "Religion as a Risk Factor for Suicide Attempt and Suicide Ideation Among Depressed Patients." 6.
[273] Kenneth Pargament, Margaret Feuille, and Donna Burdzy, "The Brief RCOPE: Current Psychometric Status of a Short Measure of Religious Coping," *Religions* 2, no. 1 (March 2011): 51–76, https://doi.org/10.3390/rel2010051. 51.
[274] Ibid.
[275] The Mahdi is an individual who many Muslims believe will bring about the end of the world.

was not the final prophet in Islam, a claim which goes greatly against what the vast majority of Muslims believe.[276] This difference has made many mainstream Muslims wary of Ahmadiyya Muslims, and, in some instances, has led to persecution.[277]

Another religious scale I considered using was the Muslim Daily Religiosity Assessment Scale (MUDRAS). The MUDRAS scale was developed by Olufadi, who was writing in 2016, and has been adopted by others. He noted a limitation for most attempts to measure Muslim religiosity – that they are period specific; measuring what occurred, or how someone felt at that moment.[278] It is a criticism of my scale which I can accept, that it only takes a snapshot of religiosity there and now. Participants may also have been giving performative answers; attempting to show that they are at a certain level of religiosity to avoid fear of judgement or just to come across in a certain manner. However, for the purposes of my study, a snapshot of religiosity was the most appropriate method, as I was unable to conduct a longer-term assessment of religiosity. I cannot speak to whether my participants may have given performative answers. However, given that in response to questions such as how often they pray, I received varying levels of answers, I can assume some truth. Though, individuals may increase or decrease their prayer in response to life's stressors, so it may not necessarily be an accurate measure of religiosity.

Olufadi's MUDRAS scale has some weaknesses. Firstly, the scale was only developed using one background of Muslims – Nigerians in two Nigerian universities. Therefore, some of the conclusions about the successfulness of the scale could only be determined within the specific context of the groups that were examined. One instance that is limiting is the concentration on what Olufadi described as "sinful acts" could be to a greater extent, due his and the participants' cultural backgrounds.[279] Furthermore, describing something as sinful, has negative connotations, and by using that word, I did not want to play into any biases.

To develop my own scale, I analysed the most prominent scales which have been developed, as well as confirming which definition of religion I found most appropriate for my study. I

[276] "'An Unrighteous Cult': Ahmadiyya Face Persecution in UK," Middle East Eye, accessed October 30, 2023, https://www.middleeasteye.net/news/unrighteous-cult-ahmadiyya-face-persecution-uk.
[277] "Pakistan: Persecution of Ahmadis Must End as Authorities Attempt Shutdown of US Website," Amnesty International, February 3, 2021, https://www.amnesty.org/en/latest/press-release/2021/02/pakistan-persecution-of-ahmadis-must-end-as-authorities-attempt-shutdown-of-us-website/.
[278] Yunusa Olufadi, "Muslim Daily Religiosity Assessment Scale (MUDRAS): A New Instrument for Muslim Religiosity Research and Practice," *Psychology of Religion and Spirituality* 9 (2017): 165–79, https://doi.org/10.1037/rel0000074. 166.
[279] Ibid, 170.

used three of Glock and Stark's dimensions of religion as the basis for what I would assess. These were: ideological, ritualistic, and intellectual. The first can be seen through participants identifying as Muslim by participating in my research in addition to the question around keeping dietary laws. The second can be seen through questions around ritual practice such as prayer. The latter can be seen through questions around whether participants followed a particular Islamic school of thought, or whether they had a certain level of achievement in Islamic education.

Pre-Interview Questionnaires as a Form of a Religiosity Scale

Though I began this study wanting to have a questionnaire which was formalised and written, this idea changed for two reasons. Firstly, I wanted to limit any factors that could potentially put-off an interviewee from taking part in the study. I felt that participants may already be reluctant to join a study where they would speak about their mental health and, if more pre-work was required before taking part in the interview, this could dissuade them entirely. Secondly, I wanted to give the participants space to give nuanced answers to these questions, understanding that often questions around identity and practice cannot be fitted neatly into checkboxes.

The pre-interview questionnaire also asked the participants to identify their ethnicity, nationality and age. These factors were measured using the same questions and multiple-choice answers used by the British government on official forms. This is because participants would then be familiar with identifying themselves using the same language.

I began all interviews by obtaining verbal consent from participants. Though I had already received their signed consent forms, I wanted to affirm that they had understood the form and did not have any further questions. I also wanted to ensure I had a second form of consent in case there were any issues.

The questions I used to determine participants' religiosity and background were as followed, and the final two questions on this list were added slightly later, with the advice of my supervisors:

How old are you?

I wanted to analyse any differences in answers between those of different ages, and to see whether age was a factor in different views of mental health.

What is your ethnicity?
This was to see if ethnicity or cultural background had an influence on their answers regarding mental illness.

Do you follow any particular Islamic denomination or school of thought?
This was to assess if there was a difference in opinions between different schools of thought. Though there was general familiarity with knowing the existence of different schools, there were rarely participants who followed a school of thought extensively, beyond association through family. An option to say "no" to this question was given, and some participants were not aware of schools of thought within Islam.

Are you a convert to Islam?
To discover any differences between those who had converted to Islam and those born into Muslim families.

Do you keep a halal diet, by that I mean abstaining from pork and alcohol?
A measure of ritualistic religiosity. This idea was explored earlier in the section on religiosity questionnaires. For this question, I could have gone beyond these elements, into consumption of specific halal products, however I wanted to cast the net fairly wide, while still asking a question about diet.

Do you perform salah daily/how many times a day do you perform salah?[280]
A measure of ritualistic religiosity. In answers to this, participants additionally mentioned attendance to Friday prayers. A concern with this question, is that some participants felt almost as if they needed to prove something by answering this question. For example, when Participant 17 was asked this question, he responded with 'Wallahi, I prayed today'. [281] He was swearing by God that he had prayed today.

Are you an immigrant to the UK, or 1st, 2nd generations etc.?

[280] I used the term 'salah' instead of 'prayer', as it would be a term that participants are more used to hearing this phrase in Arabic.
[281] Quote from Participant 17; In this case the phrase 'Wallahi' means I swear by Allah.

To establish any differences between those who were born in Wales/England, and those who immigrated, or whose parents immigrated.

Are you married?
To establish any differences between those who are married and those who are unmarried. The impact of this can be seen in later questions, when participants discuss the support network provided by their spouse, who they turn to when they have any mental health struggles.

What is your highest level of education achieved? (Islamic education as well as secular education).
To establish any differences between education levels of participants and their opinions. It was important to also establish levels of academic education, something which was added into the interviews after a few participants had already been interviewed, as the research may have shown that there was a correlation between views of mental health and understanding of Islam. This was discussed with my supervisors and was added after a suggestion from them. As it was a demographical question rather than a question explicitly related to my research, I do not believe this largely skewed the data outcomes. In particular, because this question did not explicitly link to my research ideas of masculinity, culture, or religion. Similarly, I did not find any direct link between level of Islamic or secular education and a particular view of mental illness. One limitation of this question which I found, is that those who are qualified as medical doctors, despite their extensive training, have the highest education level of an undergraduate degree. If I was to redo this research, I would also ask individuals their occupation, and explore the results together.

Where do you get your religious advice from?
This was added to ascertain where individuals seek religious advice, and whether this would have an effect on their attitudes to mental ill health. There were a large number of individuals who obtained their advice from Google or social media. This question was also added after a few participants had already been interviewed, after discussing with my supervisors.

Pargament, Smith, Koenig and Perez succinctly described one of the aims of my research. They state that ‘positive and negative religious coping methods have been linked to better

mental health and greater distress respectively'.[282] Their study however mainly concentrated only on Christian participants. Though the study looked at three different samples, overall, the sample used in this study was majority white and female. Conversely to my study, the majority of those whom I interviewed were male Muslims of colour.[283] While Pargament et al were studying a similar phenomenon to myself, their sample group was vastly different that any conclusions drawn from their study could not necessarily be replicated in mine but may broadly apply.

Similarly, in their methodologies, they concentrated each sample on a particular stressor. While I specifically examined experiences of mental illness in relation to one particular stressor (namely the COVID-19 pandemic), it was not initially a key reason for this study, nor did I examine any other specific experiences. However, due to the time during which this study took place, it may have been uninformed to not acknowledge its impact.

Interviews

Throughout the interviews, I was conscious of my intended lines of inquiry. The themes from my Literature Review and my research questions were used to formulate and structure the questions of the semi-structured interviews. The general research questions and topics I posited at the beginning of this thesis are as follows:

- Is Islam seen as more of a risk or protector of mental ill health amongst Muslim men living in Wales?
- Do opinions of mental ill health differ depending on the condition?
- The role of race and culture in experiences of mental ill health.

The process of interviewing Muslim men about their mental health has been, at times, challenging. As many participants shared with me that it was the first time that they had spoken to anyone about their mental health, I felt privileged that they were able to have an outlet in the form of this interview. Because of this disclosure, I found it important to let participants speak, where possible, without interruption and without a strict structure; letting

[282] Kenneth I. Pargament et al., "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion* 37, no. 4 (1998): 710–24, https://doi.org/10.2307/1388152, 71.
[283] Ibid.

them tell me what was important and what I should be focussing on and not the other way around.

Though Affleck and Macdonald found that semi-structured interviews were 'not well suited for studying topics that participants find difficult to speak about', I found the opposite.[284] Prior to undertaking this research, I worked in a role conducting qualitative interviews with those in services such as mental health, domestic abuse, and modern-day slavery. Throughout this role, I utilised a semi-structured interview style which worked well with difficult topics. This is because the semi-structured style allows for the researcher to obtain the information that they need to complete their study, but also allows for the participants to have adequate time to tell the researcher which parts of their experiences they believe are the most important to share. Mental health is a difficult topic to speak about, and many of my participants in this study disclosed that their interview with me was the first time they had spoken about many of these topics. Without the minor prompting and narrowing down of topics that the semi-structured interview allowed, participants would have felt overwhelmed and unsure of what to say in the interviews. This method allowed participants to keep within the allotted topic, but also to be able to fully express themselves. It also allowed me as a researcher to ask for clarification from participants and to follow up on any points which needed further explanation. Using some prepared questions allowed participants to describe their experiences and views in a more guided and detailed way. Many qualitative studies interviewing participants about their mental health have used semi-structured interviews for similar reasons to myself. Brazier et al, in their study of mental health service users conducted in the north of England, used this interview type to ensure a "common set of questions was asked".[285] This method aids measurability and uniformity within studies which reinforces the validity of findings.

For the interview process, I could have chosen to also follow either a structured interview approach or a narrative interview approach; though after consideration, both seemed highly inappropriate given the topic. A structured interview would not have allowed for the human element of an interview to be expressed due to its rigidity in questioning, an element which is much needed when interviewing about sensitive topics such as mental health. One issue I

[284] Affleck, Glass, and Macdonald, "The Limitations of Language." 155.
[285] John Brazier et al., 'A Systematic Review, Psychometric Analysis and Qualitative Assessment of Generic Preference-Based Measures of Health in Mental Health Populations and the Estimation of Mapping Functions from Widely Used Specific Measures', *Health Technology Assessment* 18, no. 34 (May 2014), https://www.ncbi.nlm.nih.gov/books/NBK262013/. 76.

did find in some of the earlier interviews, was knowing when and if to stop the participants when they were going off the main topic or speaking for an extended period of time. In the end, I wanted to ensure that participants were given enough freedom, where possible, to emphasise what *they* felt were the most important points. While I could have asked participants whether they were okay with an increase in interview time, I felt it was more important to honour the hour limit to protect the participants and my mental health, as it can be a heavy topic to discuss for a long period of time.

When individuals who have not spoken about certain topics before are not given boundaries or limits, it could lead to inappropriate information being discussed – details which I may not be adequately trained to deal with. For example, though I cover a question about suicide, I ensure I do not ask participants about their own suicidal ideations, only about community responses to any suicide of which they may be aware. Had a narrative interview been selected, participants would be free to speak about any topic, perhaps seeing the interview as more of a therapy session than a research setting. Some may also find the process distressing which is why it was extremely important to create a robust debrief plan. This post-interview support consisted of a verbal, more informal, debriefing session directly after the interview in addition to a formalised, written debrief sheet which was emailed to the participants in the hours after the interview. The debrief sheet contained information and resources for mental health support that a participant may have found useful. These were either given in person or sent via email if the interview was conducted online.

During the early interviews, I found that I allowed participants a less structured semi-structured interview. This is because, working with Grounded Theory in mind, I did not want to assume answers from participants. Though I could presume topics and themes that would be present as a result of the extensive literature review conducted, I did not want to narrow down questions too far, or ask too many, as I wanted to establish my own themes from the research. It was a delicate balancing act.

I had a pool of questions which I generally followed, and would change the order, omit, or add questions depending on the participant's answers and attitudes. These questions are detailed below and given in their most basic form. When asking during interviews, they were segued from previous questions and asked in a more friendly manner.

All participants were asked a set number of the same questions as detailed below which are represented by the letter M for mandatory. I then had a list of other questions which I asked when the participant was responsive to the initial set questions. These are represented by the letter O for optional. The final categorisation of questions were follow-up questions based on the answers the participant gives. They were specific to each interview and varied depending on what I needed further detail in.

The bulk of the interviews consisted of both specific questions regarding Islam, masculinity and mental health, in addition to general topics I wanted to cover, which I formed questions about depending on how the conversation was going.

(M) What does it mean to be a man in your culture/what is the role of a man in your culture/what is expected of a man in your culture?

This question had three different forms, dependent on whether participants felt they could answer the initial question. If they needed prompting then I would ask what the role of a man in their culture is, or what is expected of men in their culture. As Croucher et al., determine, there is "not one accepted definition" for religion or culture, and that these terms, along with the term "communication" may intertwine.[286] Croucher et al., argue that "religion is an essential layer of culture", suggesting an integration level that the latter may not exist without the former. Bonney argues that "cultures tend to be localized, whereas religions are not".[287] He uses the idea of the hijab to iterate his point, saying that while the Qur'an commands modesty, its interpretations are more localised, and rooted in culture, women in Afghanistan may wear a burqa, and women in India may wear a dupatta, for example.[288] As will be evidenced in interviews, participants believed in culture as distinct from religion in certain aspects, such as how mental health may be perceived or interpreted. In some instances, participants blurred the line between religion and culture, leading to further questions on how they can be distinct. Based on these discussions, the definition of culture which this thesis utilises is one which acknowledges culture based on the individual's ethnicity of heritage, understands that there does not exist one unified definition and distinction of culture.

[286] Stephen M. Croucher et al., 'Religion, Culture, and Communication' (Oxford University Press, January 2017), https://doi.org/10.1093/acrefore/9780190228613.013.166. 1.
[287] Richard Bonney, 'Reflections on the Differences between Religion and Culture', *Clinical Cornerstone* 6, no. 1 (2004): 25–33, https://doi.org/10.1016/S1098-3597(04)90004-X. 26.
[288] Ibid.

(M) What are/are not the roles and responsibilities of a Muslim man?
I wanted to assess whether there were certain roles and responsibilities attributed to Muslim men, usually participants would refer back to this question when discussing expectations of Muslim men on their mental health in a later question.

(M) What does it mean to be a Muslim man in the UK? /What does it mean to you to be a Muslim man in the UK? / What does it mean to you to be a Muslim man in Wales?
It's interesting to understand what individuals' perceptions are in regard to their identity of being a Muslim man in the UK or Wales. This does not presume identity because it is phrased in a way devoid of speculation. This question forms the basis then for establishing the link between identity and mental health, if any. This also links to the next question in particular for individuals not originally from the U.K. or Wales.

(M) What does it mean to be masculine in Islam? / What does it mean to be a man in Islam?
To understand the if there is a difference to what they feel Islam tells them about masculinity, compared to their cultural ideas of masculinity. These ideas, and the possible tension between the two, may have an impact on their views and experiences of mental ill health.

(M) Do you think expectations around Muslim men/pressures have an effect on their mental health? [Addition] – To what extent does Islamophobia and racism play a part too?
This question was designed to determine definitively whether Muslim men themselves feel that expectations put upon them negatively affect their mental health. The definition of Islamophobia that I have been utilising was outlined in the literature review of this thesis. The additional question was added to explore other factors that may have an impact on mental health.

(M) Tell me your experiences of mental ill health? Tell me about any coping mechanisms?
This question was more open-ended, in order for the participant to either tell me about their own experiences, or that of someone they know. If they had begun speaking about how they overcame periods of mental ill health, I would further enquire about coping mechanisms.

(M) What are your views on mental illness – what do you think causes it? /Is it different for different conditions? / Have you ever heard the notion that *djinn* cause mental illness?
This question was asked to determine whether views on mental illness are different for different conditions. For example, whether more common illnesses such as depression and anxiety are more legitimised and known, than conditions such as schizophrenia or bipolar disorder. Additionally, as I had hypothesised from conducting my Literature Review, that some cultural backgrounds placed more value on djinn causing mental ill health that others, I wanted to assess whether that was the case amongst the participants I interviewed.

(M) Is there stigma and taboo around discussing mental illness? And are attitudes changing?
To establish whether participants felt there was stigma or taboo around mental illness and mental health, whether in the Muslim community, the wider community, or whatever they felt was their definition of "community".

(M) If you had a mental health crisis, where would you go for help?
To determine if participants were aware of where they could go to seek help for mental health.

(O) Have you ever sought medical/professional help for mental illness?
To determine whether they feel comfortable in seeking help for mental ill health, if and when needed.

(M) What would stop you accessing mental health support?
To assess the barriers of accessing mental health support, and measuring them against Inayat's determined barriers, as mentioned in the literature review. Additionally, discussing whether further barriers to accessing support, exist.

(M) Does the Muslim community play a part in? What role?
I asked about whether there was a role of the community in general in preventing mental ill health or promoting good mental health. This could be through using the community as a support mechanism when experiencing poor mental health, or fear of judgement from the community when speaking out about mental health.

(M) What has been the impact, if any, of coronavirus pandemic on your mental health? [Prompt] Mosques closed – did this have an impact? Ramadan?

I wanted to assess whether the coronavirus pandemic had an impact on their mental health. I was particularly keen to look at the role of the community and the mosque, and whether those things affected their mental health.

(O) Do you know of anyone who has died by suicide?
If the participant answered yes, I would ask further questions about whether the person was Muslim, and if so, how the community reacted to their death. For example, whether there were open and honest discussions around suicide. Though last in this list, I did not make questions around suicide the last, as I did not want that to be the final point discussed with participants. This was part of ensuring a positive interview experience for participants. This was also an optional question as participants may have not engaged with earlier questions, so it would not have been appropriate to ask this one.

Abu Raiya also examines the relationship between religiosity and coping with mental and physical health. He emphasises Pargament, Smith, Koenig and Perez's study on the scale of religious coping where they found that this can take two thresholds: positive religious coping and negative religious coping. This is something I observed during my interview process, examining whether participants' answers are conducive to positive or negative religious coping. [289] Some participants identified that Islam helped them cope with stressors, particularly in times like during the COVID pandemic. This is further explored in the Discussion and Data chapters of this thesis.

I aimed to keep the interviews to no more than an hour in length, as I felt that any longer would be too much for the participant to handle. Even if I did not get a chance to finish all of the questions on my list, I felt the wellbeing of my participants was more important. Additionally, I felt it was important for participants to not be disturbed frequently while speaking a narrative, even if it meant they were veering off topic; I wanted to let them tell me what was important about their views and experiences. Keeping to this time also ensured I could provide an adequate debriefing time for participants.

The Impact of the COVID-19 on the Research

[289] Abu Raiya et al., "A Psychological Measure of Islamic Religiousness." 12.

When this project was initially conceptualised in February 2020, we could have foreseen the unprecedented year which lay ahead. The COVID-19 pandemic not only inhibited certain methodological practices such as face to face individual or group interviews, but the year itself had a great impact on many peoples' mental health. Therefore, original concentrations for interview questions had to be reformulated, or added to, to include information about the pandemic. The impact of COVID-19 made a project such as this even more pertinent and meant that individuals were more willing to speak about their mental health as there had been an increase of concentration around the subject as a result of the pandemic; and made mental health a more palatable and acceptable conversation.

Sociologists have begun to discuss the impact that the COVID-19 pandemic has had on studies, both for researchers and participants. Vindrola-Padros et al noted that sociologists may struggle to conduct research in a pandemic because qualitative research may be considered too "intrusive or burdensome" for participants.[290] On the other hand, they discuss how qualitative research may be increasingly important in a pandemic as it examines reasonings behind quantitative research. My study, in one aspect, analyses the reasons behind mental health worsening as a result of the COVID-19 pandemic.

Had COVID-19 not been an issue, there are some methods which I may have changed. Having volunteered within communities in South Wales throughout my PhD experience, I believe conducting focus groups would have enabled me to obtain a broader amount of data through witnessing the relationships and debates between the participants. Participant 18 referred to the desire to establish group sessions for mental health support to assist Muslim men, saying, 'I just wish that like we could have like a group session where you kind of just among us in men and not in a counselling kind of way, but more than the fellowship kind of way. '[291] Though he was referring to group sessions to aid in recovery of mental ill health or for the upkeep of positive mental health, this suggests that focus groups as a method of data collection may also work in the Welsh Muslim male context. However, it is an area where there is a need for further exploration.

[290] Cecilia Vindrola-Padros et al., "Carrying Out Rapid Qualitative Research During a Pandemic: Emerging Lessons From COVID-19," *Qualitative Health Research* 30, no. 14 (December 1, 2020): 2192–2204, https://doi.org/10.1177/1049732320951526. 2193.
[291] Quote from Participant 18

Sampling

The COVID-19 pandemic, which reached the UK in March 2020, had an effect on my sampling techniques. As I could not physically go to events or mosques and talk to individuals about my research and ask whether they would be able to participate, my main sources of participants were through social media or connections through the Muslim Council of Wales. However, through social media, I was only able to attract one "type" of participant, similar to myself and those I may connect with. These people are generally younger, educated, and have perhaps more awareness of mental health issues than the general Muslim population. Similarly, with recruiting through the Muslim Council of Wales and online, I was only able to reach computer-literate individuals, who although may be slightly older than those found through my own social media, shared a similar educational level.

Though I wanted to obtain the views and experiences of Muslim men and mental health, I did not want to interview those already under the care of services such as the Community Mental Health Team. This is because I felt I did not want to potentially trigger any participants by not fully being able to understand their diagnoses. As mentioned previously, many studies on health outcomes have had a higher level of female participation compared with their male counterparts, implying that men are harder to recruit, and less likely to speak about their health. Therefore, I found it challenging to find men to interview. Coupling this aspect with research mentioned in the literature review which states that men are less likely to speak about their difficulties, and the continued impact of global pandemic, meant it was difficult to find men open to, or willing to, speak with me. As I was unable to offer any material reimbursement for this project, this may have deterred some who would not have been interested in being interviewed for the simple reasons of assisting in a mental health study.

Chaudhrey (2020) studied how second-generation Muslim men may experience mental health within a faith context. All participants in the study conducted by Chaudhrey were between 20 and 35 years old, second-generation Muslims specifically, and either of a South Asian or Arab background. Each of Chaudhrey's participants also presented with a mental health problem. While there are similarities between Chaudhrey's project and my own, the differences present in that Chaudhrey's research examined specific demographics of Muslim

men and concentrated on research from a mainly psychological point of view.[292] Within my research, I wanted to ensure I allowed for individuals from any ethnic background to participate. The reason for this is twofold. Firstly, I was already limiting potential participants by restricting the demographics to south Wales. Additionally, I wanted to determine whether factors such as being a first, second, or third generation immigrant may affect attitudes towards mental health.

Arendell, in her study of divorced fathers in New York State, argued that due to the convenience methods used when recruiting participants, 'generalisations from the findings of this study are inappropriate.'[293] She noted that participants partake in research for their own reasons; and in this instance, it could be that the men were angry about divorce. This attitude could be mirrored with my participants: only those with strong feelings about, or experiences with, mental health would be interested in participating.

In my view, participants took part in interviews for personal reasons as the participants did not receive any financial rewards for taking part. The first is as part of a favour. Whether that was because participants were being interviewed as a favour to myself, or to a mutual friend or acquaintance, individuals will participate in research as a "favour". Knowing the researcher personally gives trust to the participant, and they are more likely to take part. Secondly, the participant may take part because they are passionate about mental health and have strong feelings about the topic. Whatever the views of participants are around mental health, they would be strong one way or the other in order to take part. The determining factors could be either of those mentioned, or an overlap. Generally, individuals will not participate if they feel indifferent to the subject matter, unless doing so as a "favour" to help out an individual or member of the community. Nor will they participate if they feel the nature of the study is inherently flawed or has no worth to them, even if they themselves suffer with mental ill health. It is due to these factors that studies of this nature will not be able to obtain a wide variety or range of participants. However, unlike Arendell, I can make generalisations from my study. Even if my study only interviews those with a personal interest in mental health, in their interviews they still reference the wider community and general views around the topic, including stigma. In fact, some participants were more open

[292] Sara Chaudhrey, "How Do Second Generation Muslim Men Experience Mental Health Problems within the Context of Their Faith: An IPA Study," (PhD diss., London Metropolitan University, 2020), 83.
[293] Arendell, "Reflections on the Researcher-Researched Relationship." 344.

when speaking generally about viewpoints and experiences amongst the wider community, friends, and family.

Based on these issues, I experienced some selection bias in my study. Participants who chose to be interviewed in such a study would broadly fit into two categories. First, they may be people who I know who participated with the sole reason to help me with my research. Or they may be individuals with a particular interest in mental health. To combat this bias, I ensured I had "buy-in" for my study from groups and individuals, such as the Muslim Council of Wales, who could enable my access to participants who otherwise would not have engaged with the study. Furthermore, I engaged with social and voluntary groups in and around Wales who were likely to contain the demographics I needed for this study. I shared with them the purposes and rationale behind the study, and they were able to share the recruitment poster and form for me.

The first ten or so participants I obtained were through Snowball sampling through social media. Snowball sampling works as participants could recommend to others to complete the interview. However, it can be hit or miss with whether people want to admit they took part in the study; thereby impeding my ability to gain new participants via this method.

Hard to Reach or Not Reaching Hard Enough?

"Hard to reach communities" is a term which is often used when referring to certain religious and minority communities. As Valerio et al. note, the benefits of community-based research are that if it is culturally appropriate and partners with community stakeholders, it is "likely to yield sustainable improvement in prioritised outcomes".[294] Though Valerio et al make good points, I do not agree with the term that they and many others use, namely "hard-to-reach" communities. I believe that researchers often simply do not make an effort to engage with these communities on more than just a superficial basis. Therefore, to enable further

[294] Melissa A. Valerio et al., "Comparing Two Sampling Methods to Engage Hard-to-Reach Communities in Research Priority Setting," *BMC Medical Research Methodology* 16, no. 1 (October 28, 2016): 146, https://doi.org/10.1186/s12874-016-0242-z. 2.

understanding of this, I began volunteering in a predominantly Muslim community in order to better understand part of the community I was researching.

When conducting my research, I looked at studies that had taken place in the predominantly Muslim area that I volunteer and live in. Fry conducted a research project looking at how black men in South Wales perceive their risk for prostate cancer.[295] Though her primary focus was on race rather than religion, and an element of physical health rather than mental, I found parallels between our work and methodologies that could be interchangeable. Fry took a similar approach in her work in regard to using community work as a form of outreach in order to gain participants. However, she was able to recruit in a much more open way, as she used focus groups in addition to interviews as a method. This meant that participants had open assurance from others that taking part in such research was beneficial. In hindsight, this may have been a tactic I would have employed if I was to conduct the research again. Getting groups of individuals together where they all had the prompting from one another to discuss their experiences, perhaps even in their own friendship circles, I think would have been more initially effective than one-to-one interviews. I would have first held focus groups, and then used follow-up interviews with specific participants. However, this would have been increasingly difficult to achieve during the COVID pandemic.

A more appropriate term than "hard to reach" for the community I studied could be "over-researched" or experiencing "research fatigue". South Wales, and specifically Cardiff, is home to the Islam UK Centre, an institute which focuses on the study of British Muslims. Due to its location, researchers from the centre often study their surrounding areas and populations. Researchers have noted the effects that the over-saturation of research can have on a community, and the impacts on individual lives. As a result, individuals may 'become tired of engaging with research,' and be reluctant to participate in future studies.[296] Clark also specified that there is evidence to suggest that instances of over-research can be particularly found within mental health studies.[297]

[295] Sarah Fry, "Perceptions of Prostate Cancer Risk in White Working Class, African Caribbean and Somali Men Living in South East Wales: A Constructivist Grounded Theory" (PhD diss., Cardiff University, 2017).
[296] Tom Clark, "`We're Over-Researched Here!': Exploring Accounts of Research Fatigue within Qualitative Research Engagements," *Sociology* 42, no. 5 (October 2008): 953–70, https://doi.org/10.1177/0038038508094573. 956.
[297] Ibid, 955.

Reflexivity

I found my role as a researcher for this project incredibly challenging yet rewarding. Multiple participants disclosed to me that this was the first time they had discussed their mental health with anyone; the interview process, for them, became unexpectedly, a form of talking therapy. Additionally, this provided a small issue when anonymising interviews. As participants tended to reveal very specific information about themselves or about others they knew, it was difficult to toe the line between anonymity and providing informative data to add to my arguments. Where this was potentially an issue, I always erred on the side of anonymity and sacrificed the stories or data. While I felt a certain privilege to hold this position where these men felt comfortable enough to speak to me about things that were so personal, it put a lot of pressure on myself as a researcher. To combat this, I ensured I spoke with my supervisors on a regular basis to discuss any issues which arose from the interview process that negatively affected me. Though I did not explicitly divulge any information about myself, beyond that of the research project, had participants Googled my name, they may have been met with instances and works where I have openly discussed my mental health struggles. My own experiences did not come up during the interviews, but I feel it is important to note that I am aware certain information about me is readily available should participants wish to search for it.

Arendell notes that researchers come to their interviews with 'considerable social, historical, and cultural baggage', which 'inevitably influences the interactional process and the ultimate research outcome.'[298] It was important for me to be aware of any biases and baggage that I may have. As someone who continues to suffer from mental illness, I had to ensure that I would not try to mirror my experiences with the participant's. That is to say, just because my own conditions may have had certain effects on me, and a participant may have had the same conditions, I cannot draw the same conclusions. To mitigate this, I employed some of the training and knowledge learnt from previous roles working with those with mental ill health. I ensured active listening and refrained from asking unnecessarily leading questions.

Reflexivity is key to the research process; understanding which elements of myself may lead to implicit or explicit biases. As a woman studying men, consideration was made to any implications this may have had. Though men have been studying women for years, being

[298] Arendell, "Reflections on the Researcher-Researched Relationship." 342.

seen as neutral parties, I would be doing my participants a disservice by not acknowledging my positioning and possible biases as a researcher.[299] Thinking about my own bias did however prompt further questions about who can be determined as "neutral". According to Lefkowich, white cisgender men have been for years considered as neutral parties, though should not be considered as such.[300] In Dancy et al.'s study of undergraduate's awareness of male and white privilege in STEM, they noted that "white men were largely unaware of any impact of race or gender. In contrast, women of colour overwhelmingly report, consistent with results from a large body of prior research, that both race and gender impact their experiences."[301] A researcher must acknowledge the privilege and bias that comes with being a white cisgender man. However, neutrality is contingent depending on who the researcher is studying. Though proximity in similarities to those an individual is studying could point to positive bias on the side of the researcher, positive bias is important when researching marginalised and minority groups. This could be because in instances such as these, positive bias would mean that the researcher is less likely to hold any internal biases around minority groups, as they may be part of those groups themselves.

As a Muslim woman, I have some commonality with Muslim men; meaning I cannot not be considered a true outsider. My insider status as a fellow Muslim means that participants can use some religious or cultural terms without me having to ask for definitions which would otherwise possibly impede the flow of conversations or tire the participants. According to Lefkowich, relationships between female researchers and the men they study are "currently undertheorized."[302] Through this work, I aim to contribute to the understanding of this type of researcher position and provide frameworks applicable for women who wish to study men and cover issues to which they may relate. Previously in this work, I discussed the relevance of Arendell's work on women researching men, and how acknowledging her implications strengthened my study.[303]

As an individual who has volunteered, worked, and studied in the areas of Muslim mental health for many years, this thesis is close to my heart. Though I have experience in the area,

[299] Maya Lefkowich, "When Women Study Men: Gendered Implications for Qualitative Research," *International Journal of Qualitative Methods* 18 (January 1, 2019): 1609406919872388, https://doi.org/10.1177/1609406919872388. 6.
[300] Ibid, 2.
[301] Melissa Dancy et al., 'Undergraduates' Awareness of White and Male Privilege in STEM', *International Journal of STEM Education* 7, no. 1 (12 October 2020): 52, https://doi.org/10.1186/s40594-020-00250-3. 1.
[302] Lefkowich, "When Women Study Men". 2.
[303] Arendell, "Reflections on the Researcher-Researched Relationship." 342.

I did not want to come into this research thinking that I knew everything about the topic; because I did not and still do not. I wanted to ensure that I was continuously learning throughout this process, and I did not put any preconceived notions or ideas onto the participants. This is another reason I utilised Grounded Theory within this thesis, as I was able to ensure the findings from this thesis were only related to the data itself. Researcher bias and positionality is something which I endeavoured upon to remain as neutral as possible, and acknowledging when neutrality was not realistic.

It is important when working and researching in the Mental Health sector to ensure that the language used is non-judgemental. This is because if a service user or an individual feels judgement, this may discourage them from engaging with mental health services. For example, common vernacular uses the phrase '[he/she] committed suicide'. This brings negative connotations of something sinful, or illegal, further stigmatising those who have died as well as their families. For the purpose of this thesis, the phrase 'death/died by suicide' was used when referring to those who have taken their own lives.

Acquaintanceships

Throughout this study, I inevitably interviewed people I know. I categorised the participants into three categories by their proximity to me: friendships, acquaintanceships, and strangers. I found that at either end of the spectrum – friendships and strangers-participants were very open when speaking about their experiences, especially in regard to their own mental health. However, those who I have identified as "acquaintances," meaning perhaps I have met them only a handful of times or our relationship has been only professional in whatever sense of the word, were reluctant to open up, giving more generic responses to questions about their mental health and shorter answers.

Friendships are reciprocal, and I had not reached a level of reciprocity with those who fit within the "acquaintance" category. Therefore, their reluctance was understandable, given that we had not established this relationship yet. Simply, I had not yet offered any level of personal information to them; therefore, they were reluctant to offer any in return despite the established interview conditions. For the participants, I can assume that the interview may have felt one-sided; and should they have opened up, it would have changed the dynamic of

the relationship. However, I managed to obtain useful information from these interviews, even in regard to mental health experiences, as these participants would often refer to their friends' experiences or describe a situation they had seen. Though it was not necessarily their own experiences they were describing, it was still useful for this thesis.

Ethical Considerations of a Study into Religion and Mental Health

Due to the nature of this study, a clear and detailed ethical plan was necessary in order to carry out research. This began with an ethics form approved by the university's ethical committee prior to beginning interviews. As an individual experienced in the mental health sector, I was able to thoroughly understand my responsibilities as an interviewer and provided each interviewee with further information on the help available to them in their respective geographical locations. Academic and ethical standards were upheld throughout this research project, resulting in a high level of validity with the data collected.

All interviews were recorded via Microsoft Teams, in line with the University's recommendation. The interviews that were held in person were also recorded via Teams, as this was a safe and recommended way of storage. To achieve this, I set up a Teams meeting with myself, and recorded the interview. Each participant signed a written consent form prior to the questionnaire. Prior to the interview, verbal consent was also given and recorded. The identities of each participant are known only to me, and whoever the participant decided to share that information with. Each consent form was labelled for storage with a participant's number, rather than any names. Both the Teams recordings for the interviews, the transcripts and the consent forms were held on the UWTSD secure sever, and in compliance with GDPR 2018. The transcripts were redacted to delete any identifying factors, and these are only held in the original recordings. I designed my ethics form and subsequent debriefing information within the frameworks for my relevant disciplines – Sociology and Psychology, examining any negative impacts my study may have on a participant.

Due to the nature of the study, and the fact that south Wales' Muslim population is not large, it was incredibly important to me that during the write up of this study, I ensured an extremely strict anonymity process. For example, reference to jobs or specific events were omitted if they could not be appropriately anonymised. To ensure a further layer of

anonymity, I chose to use numbers for participants rather than assign them a pseudonym. This is because if I had assigned each participant a pseudonym, I would have to assign them based on their cultural backgrounds; meaning a name that was representative of their heritage, but I did not want to choose a name that was too close to the person's original name.

Due to the relatively small number of possible participants (having to fit the criteria of being male, Muslim, but also living in South Wales), I was extremely concerned with providing strong anonymity for participants. Though often common for theses, I chose not to include profiles of each participant, as, even with personal data being anonymised, I did not want participants to be identifiable. Where needed, I would refer to specific ethnicities as opposed to broader origins – for example "Lebanese" instead of "Arab". However, to avoid participants being recognised like when one identified as "Mixed", I would ensure to be broad in description. For example "South Asian and White", instead of "Bengali and White", and then, only use this when simply "Mixed" would not suffice. I am aware that the South Wales Muslim community is not only relatively small in number, but also closely-knit. Furthermore, I intend for my research to also be used and read by the people I have written about. Often, research about a community is rarely seen by that particular community. Therefore, I want to ensure that participants cannot be recognised. As someone with lived experience of mental ill health, I am particularly sensitive to the difficulties of sharing one's lived experiences, and well-versed in the consequences of when it can go wrong. This meant that I gave extra scrutiny to ensuring anonymity of my participants.

It was imperative that participants felt as comfortable as possible during the interview process. Studies have shown that men are less likely to speak about their mental health generally, and I wanted to ensure they would. In the first couple of interviews, I found that while participants would participate in the interviews in English, while saying a few religious terms in Arabic or other languages (such as *masjid* for mosque, or *ṣalaḥ* or *namaz* for prayer), they would often speak in their ethnic languages when referring to family members. As I did not want to interrupt participants for clarification during interviews, I elected to research the names of family members in different languages, and made "family tree" diagrams in Sylheti, Urdu, and Somali, with Arabic terms being those I could already understand. I kept these next to me during the interviews to refer to when needed.

Reliability and Validity of this Study

Although the terms "reliability" and "validity" are commonly attributed to quantitative research, it is important to assess them both through a qualitative lens as qualitative studies should also be considered reliable and valid. Both terms have been the subject of debate regarding whether they are appropriate measures for qualitative study.[304] Generally, this study can be seen as both reliable and valid, since it could be replicated by other researchers. This is because the methods used have been explicitly covered and I have been transparent with why certain methods and processes were used, such as the method of interviews or the anonymity process.

Musbahi et al in the "Journal of Mental Health" examined stigma with attitudes towards mental health between young British Muslims and non-Muslims.[305] They conducted a quantitative survey of second and third generation British Muslims between the ages of 18-35. They did not interview converts to Islam "as their length of time as a Muslim may be a confounder" to the study.[306] While I do not agree with this viewpoint warranting exclusion from the research, this study acknowledged similar potential variables to my study; namely that age, conversion, and immigration history could have an impact on attitudes to mental health, thereby increasing the reliability and validity of my own study. However, there were some elements in which my study differed. Namely, that I did not exclude participants from research on the basis of the same factors. My exclusions were simply down to whether the participant was under the care of a support worker or living in mental health supported housing.

The Impact and Limitations of this Study

As stated in the literature review, the topic of British Muslim men's mental health is under-researched. Therefore, this dissertation has the potential to have an influential impact on the

[304] Nahid Golafshani, "Understanding Reliability and Validity in Qualitative Research," *The Qualitative Report*, January 23, 2015, https://doi.org/10.46743/2160-3715/2003.1870. 601.
[305] Aya Musbahi et al., "Understanding the Stigma: A Novel Quantitative Study Comparing Mental Health Attitudes and Perceptions between Young British Muslims and Their Non-Muslims Peers," *Journal of Mental Health* 31, no. 1 (January 2, 2022): 92–98, https://doi.org/10.1080/09638237.2021.1952951.
[306] Ibid, 1.

field. At a time when mental health seems to be at the forefront of many organisations, this thesis adds a wealth of new data and conclusions on the topic. It can be used as evidence to create and influence policies and decisions within the mental health sector as well as aid a comprehensive understanding of Muslim men's mental health for therapists, counsellors, and other professionals. A full summary of the impact of this study can be found in the Conclusion chapter of this work. Recommendations which, if adopted, would have a positive impact on the field and can be found in the Discussion chapter of this thesis.

As this research focused on obtaining qualitative data, it lacks any quantitative conclusions. It cannot, for example, conclude that X or Y percentage of Muslim men have experienced stigma within the community as a result of their mental ill health. It can, however, give first-hand experiences of these Muslim men's experiences through which generalisations can be made; especially due to the considerations made when sampling. According to Saris and Gallhofer, if random sampling is used within a known selection of people, then it would be possible to "generalize [sic] from the sample results to the population", also depending on the number of participants relative to the wider population size.[307]

Due to the COVID-19 pandemic, the opportunity to run focus groups or other types of interviews which would require face-to-face meetings was reduced. The justification for not conducting online focus groups has also been provided. Though this is a limitation of this study, the original contribution to the field made by this work enables this study to still have validity and to fill a research gap.

Methodological Reflections

It is important for researchers to reflect more generally on their methodological approaches and how these may have impacted their participants; thereby affecting the results of the interviews. This is because through our choices of methodological approaches may have a positive or negative effect on a participant, and in this case, on the participant's mental

[307] Willem E. Saris and Irmtraud N. Gallhofer, *Design, Evaulation, and Analysis of Questionnaires for Survey Research* (John Wiley & Sons, Inc, 2007). 9.

health. For example, a face-to-face interview may be more challenging for a participant than completing a survey. One key priority for my research was to always ensure participants' comfort before, during, and after the interviews. When scheduling the interviews, I used a generic event title of "Interview", rather than something more specific such as "Muslim men's mental health interview" unless they requested otherwise, to ensure that should another person see their calendar the event would appear fairly ambiguous; meaning they would not feel as though they had to justify or answer questions about said interview. I also wanted to ensure I was able to put participants at ease, not only because it would yield better results and encourage more openness to discussions with myself; but also at a more baseline level, I felt extremely grateful that they were sharing their experiences with me and wanted to make sure it was as pleasant an experience as possible for each of my interviewees. In order to add an extra level of privacy and security to my interviews, I ensured my Amazon smart speaker – "Alexa" had the microphone switched off, so it would not unintentionally capture parts of the interview. The challenges of smart technology and AI involvement in this increasingly digital research age could be an area of exploration for future study.

Many participants thanked me for undertaking this research and stressed to me the importance of this work. These sentiments were often expressed post-interview, during the debriefing segment which allowed the participants to discuss their feelings on the process, and to ask any questions which they did not previously have the opportunity to be addressed. One expressed his thanks to me when I asked at the end of the interview whether he had anything he wanted to add on the topics which we had covered.

> *"Thank you for doing such an important piece of work. I think, I hope this changes things, and I think it's so important."*[308]

Similarly, Participant 17, when asked if he wanted to add to anything he had said during the interview, shared,

> *"I'm glad I talked about mental health today… Before this interview… I was very nervous, very nervous before this interview, but it was actually interesting and amazing of what I actually thought about. 'Cause my answers, I didn't think I would come up with these answers initially, but then you made me actually start thinking about certain things… I actually found certain aspects of life that I didn't know by myself, so thank you very much. I'm grateful for having this interview."*[309]

[308] Quote from Participant 12
[309] Quote from Participant 17

It is quotes and feelings such as these which gave me an increased confidence in my work, as I felt as though I had some level of participant buy-in, that people were not participating just as a favour to myself or someone else, but because they really believed in my research, and wanted it to make a real difference. Furthermore, it led me to believe that more Muslim men could benefit from having someone with which to discuss their mental health. This is discussed in more detail in the next chapters.

Conclusion of the Methodology Chapter

This chapter has examined the methodological frameworks behind this study. It has provided analyses of different religiosity questionnaires which have been used to assess religion in Muslims. It also has discussed the learnings from the interview process and how other researchers may be able to conduct mental health research during, and considering the impact of, a global pandemic. The chapter detailed the justification for a qualitative research study involving interviews rather than any other methodological choice, such as a quantitative study. The next chapter will set out the main themes seen in the data.

This chapter summarised the methodological arguments behind this study and examined Durkheim's idea of functionalism and argued that this theory was best utilised within this study. It considered Marx and Weber's theories of religion but ultimately concluded these were inappropriate for this study.

It discussed Said's theory of Orientalism and how it relates to Muslim mental health; the concept of being seen as an O*ther* and how this may impact access to mental health services in addition to the experience of services themselves.

This chapter also covered the limitations of this study due to the COVID-19 pandemic. The constraints felt cannot be underestimated. The uncertainty of the pandemic compounded with unprecedented restrictions to social life meant that academically traditional ways of garnering participants and conducting interviews were changed. On a more positive note, the pandemic meant that more tasks were completed online; and participants had an increased familiarity with online applications such as Teams, which was used for this study,

or Zoom, more generally.[310] Therefore, there was more fluency with these online systems, and participants were less likely to be put-off by having to hold interviews online. However, the timing at which this thesis commenced meant fieldwork occurred in an almost limbo-like setting, where society was only just becoming accustomed to online interactions. As it was still early in this new-found way of communication, there were limited resources and advice available on how to effectively conduct interviews over a screen. Consequently, this meant as a researcher I was constantly adapting to new methods.

The following chapter will outline the data gathered in relation to my methodological concerns. It will cover the key themes as summarised in the Literature Review section of this work. It will contain a reflection of the interviews themselves and discuss the organisation of the data.

[310] "Zoom, Microsoft Teams, and Slack Have Exploded Due to the COVID-19 Pandemic. Can They Hold onto This Growth?," GLG, accessed December 5, 2023, https://glginsights.com/articles/zoom-microsoft-teams-and-slack-have-exploded-due-to-the-covid-19-pandemic-can-they-hold-onto-this-growth/.

CHAPTER 4 – DATA

This chapter will cover the interview process and results. It seeks to provide a summary of key themes across the data and compare and contrast the different responses to questions. This chapter will also utilise ideas found in the Literature Review to mirror themes found in the data, though these ideas are presented in a more in-depth way in the Discussion chapter.

I completed a total of 21 interviews which took place over the period of approximately one year. The participants lived across South Wales and represented a diversity of ages, ethnicities, and marital statuses. As covered in the Methodology chapter, had I not been restricted to mainly online interviews, I would have been able to increase the participant numbers, both through in-person participation and focus groups. Due to the limitations imposed by the COVID-19 pandemic, I was not able to carry out this research through methods such as focus groups and workshops. However, within the limitations of what I was able to work with, I was able to discover several outcomes that prove to be empirically interesting and worth further consideration.

Many of the quotes used are the full, long answer to a question by a participant. I felt it was important to provide quotes in full in order to capture the nuances said by a participant. Additionally, as this thesis is the first study of Muslim men in Wales which looks at mental health, I wanted to include as much data as possible to enable further research based off of this work. Furthermore, as I wanted to ensure complete anonymity for my participants, many details mentioned had to be omitted from their quotes. Therefore, I kept quotes without specific details fairly long (ensuring they made sense), so that enough quality analysis could take place. The quotes have been edited for brevity and to ensure grammatical clarity, for example, filler words such as “erm” or “uh” have been omitted. Where this filler words such as “like”, or the repeating of words occur, they have sometimes been left in, dependent on the tone of voice of the participant, such as when the participant wanted to add emphasis to a point. Where the participant made grammatical errors, they were corrected, and additional words were placed within square brackets “[]”. These were also used when a participant may

have stated the specific name of a place such as "Eastbourne", and it was omitted and replaced with a generic place name such as [town].[311]

Reflection on Interviews

In order to better process the interviews, I kept a diary following each one. Some entries that I personally found more difficult due to the subjects discussed, were not completed until a few days post-interview; giving myself space to both think deeply, and not think about the interview at all. However, I still took general notes during each interview. The diary entries were more of an in-depth look to reflect on how the interviews made me feel, and on myself as an interviewer. In the earlier interviews, I found the process challenging as the notion that this was the first time each participant had discussed their mental health was prevalent in most interviews. Some interviews I found exceptionally challenging, as it was clear that the participant was struggling with their mental health. This was mediated by having a robust de-briefing session after the interview and providing participants with appropriate mental health resources.

Organisation of Data

In order to organise and code my data in the best way, I utilised an excel spreadsheet where I selected the most useful quotes from each question that I asked each participant. In order to begin coding, I associated, "general concepts (codes) to singular incidences in the data".[312]

The participants represented a wide range of ethnicities and cultural backgrounds. They self-defined their ethnicity since it was important for my research to allow for this, because it could prompt wider conversations around identity and ethnicity. As an example, some participants who are Somali sometimes identified themselves as Somali, and sometimes as African or Black African. Additionally, I wanted to see whether participants who identified as "Mixed", identified more with one part of their ethnicity than another. It is also interesting

[311] This is not a real example.
[312] Maike Vollstedt and Sebastian Rezat, "An Introduction to Grounded Theory with a Special Focus on Axial Coding and the Coding Paradigm," in *Compendium for Early Career Researchers in Mathematics Education*, ed. Gabriele Kaiser and Norma Presmeg, ICME-13 Monographs (Cham: Springer International Publishing, 2019), 81–100, https://doi.org/10.1007/978-3-030-15636-7_4. 86.

to note which participants felt that “British” or “Welsh” was part of their identity. It is also interesting that many perhaps conflated ethnicity and nationality, with some describing themselves as British or Welsh despite not being ethnically so. The ethnicities of the participants were as follows:

4 participants defined themselves as “Mixed”.
2 participants defined themselves as “Somali”.
2 participants defined themselves as “Black African or African”.
6 participants defined themselves as “British Pakistani or Pakistani”.
1 participant defined themself as “Indian or Welsh Indian”.
2 participants defined themselves as “Bangladeshi or British Bangladeshi”.
1 participant defined themselves as “White”.
2 participants defined themselves as “Arab or British Arab”.
1 participant defined themself as “Asian”.

As noted, the category “Mixed”, is intentionally left broad and vague. Due to the close-knit nature of the Welsh Muslim community (something I have first-hand experience of through my work with the Muslim Council of Wales), individuals may be identifiable to members of the community if specificities of their race are shared.

Key Themes

This section will address the various themes which were found during interviews with participants. They will be discussed in more depth in the Discussion section; however, this section broadly covers the common important themes which arose from the coding of the research.

The Role of Stigma

Stigma and taboo were found to be significant factors not only in regard to participants choosing not to seek support for their mental ill health, but also to generally discussing mental health. This stigma was noted as being not only in the wider community and the

Muslim community, but also self-stigmatisation when it came to mental health or mental ill health. The stigma discussed by participants was not just around mental health itself, but stigma around being part of a community which discusses mental health. Participant 1 noted that he would not choose to publicly discuss his own mental health despite acknowledging the help it may bring to other sufferers. He felt it may pigeonhole him into a certain section of society; one which other people in their community may believe he is part of.

> '*But now I think what's happening is a certain section of society is speaking about it [mental health/mental illness], and so if you start speaking about it, there's an assumption or presumption or idea that you're part of that community of people who are speaking about it, and you may or may not belong to that community. … There's certainly a more socially active social justice-oriented community. They tend to be younger. They tend to be sort of in favour of things like racial emancipation, but also feminism and emancipation of women as well as in accounting for that as well. They would also be very conscious about sort of ensuring LGBT communities have fair access and treatment in society, and this kind of like a package of key social values that I think are very common. And very vocally spoken about by the community in question. Or maybe community is the wrong word, I think. Identity of movement might be better. Movement might be a better word.'*[313]

This participant also felt that as a result of being involved within the Muslim community, there was an expectation that he would be vague about his own life. He felt that should an individual discuss their mental health openly, particularly as a man, he would be classified as "left-leaning" or as a part of a "social justice crowd", and that these characteristics could be seen as negative to the wider Muslim community. This may also link to an earlier point made in this thesis about the conflation between mental health and mental illness. Because many individuals say mental health when they mean to say mental illness, this could cause both confusion and a negative sentiment.

> *'Weirdly, I think it feels as if you did start speaking about, or if I was, you know, to start speaking about it openly, I feel there's also this, you know, sort of pigeonholing that would happen- would be like, "oh, he's, you know, part of the left-leaning social justice crowd." And it's not that I do not want to be part of that community for myself. I need to appear a lot more bland and a lot more nondescript.'*[314]

Another interesting element on the topic of stigma in mental health was mentioned by Participant 9 who discussed stigma as a result of the lack of conversations around mental health within Muslim communities. While he noted that some groups of young people may

[313] Quote from Participant 1
[314] Quote from Participant 1

converse about mental health, he also said that these conversations are sporadic. When asked whether he felt that was a stigma around mental health and mental illness within the Muslim community, the participant said,

> '*Yeah massively. I do not think it's ever been properly talked about, changed, or challenged. The only people I ever see talk about it are certain groups of young people who have that conversation here and there. And some people who you know talk about it here and there, but I think on a community scale, it's not something that happens, and I do not know what it is, it's obviously a lot of different issues contributing to that. But I think yeah, it's a massive issue and not just for young people, not just for men. I think it's an issue for families and everybody involved, but there is just not a realisation yet that this is something that they should look into.*'[315]

Participant 12 noted two barriers he found to combatting mental ill health within the Muslim community. He said,

> '*I think that, number one, we do not talk about as Muslims enough, we do not. We do not understand it enough. Number two, we probably do not want to fund it. You know. You know we're not even putting financially into it. Even as a people generally outside, you know, even outside of some community so- but it's improving for sure. And inshallah, I think it will get better. I hope so, but you know our surroundings and our situation as a people is getting worse, so I do not know how that's going to counteract all the hard work.*'[316]

The barriers he noted were the lack of understanding of mental health and mental illness within the Muslim community, and the hesitance within the community to fund mental health. As we know, the waiting times for NHS services in Wales are extremely long, and mental health services are no exception.[317] Therefore, even if an individual wanted to seek support, by the time the services were available, their condition may have worsened, or they may have become disillusioned with the process. Though the participant felt that things were improving, he did know through which means this could be achieved. He did acknowledge that there was an increase of awareness and understanding throughout younger generations, particularly due to the emergence of social media, saying,

> '*I think, you know, our generation, is definitely understanding it better. You know, when you look at social media across all the platforms: Twitter, Facebook, Instagram, TikTok, whatever you talk about it, you know people are talking about*

[315] Quote from Participant 9
[316] Quote from Participant 12
[317] "NHS Wales Waiting Times: 75,000 Outpatient Waits of Year," *BBC News*, February 23, 2023, sec. Wales, https://www.bbc.com/news/uk-wales-64742924.

mental health a lot more that understanding, and the awareness is- it's much better.'[318]

This topic of potential changing attitudes around mental health in the Muslim community will be explored further later in this thesis. One of the questions asked to many participants was whether they felt attitudes towards mental health were changing within the Muslim community. Participants affirmed that indeed they felt things were changing in a positive manner, particularly amongst the younger generations.

Djinn and Ideas of Mental Ill Health

All participants had heard of the notion that djinn cause mental illness. However, each participant had varying levels of belief in this idea. One Pakistani participant felt that this idea was extremely prevalent in South Asian communities; and it was something that he had heard more of from being around Muslims of that background. He stated,

'*I think that [djinn] is a massive issue in Southeast Asian culture. You know you- you hear of anyone who's got some sort of mental health issue and it's automatically a djinn. I do believe in djinn, and I do believe they exist, and I do believe that sometimes people may be suffering from mental health issues because of them... It's not always about djinn, it is just sometimes… You know, we believe that they do exist, so you know, I cannot deny that they do not exist. Having heard and seen this person change, I would say that yes, it does affect some people; but I'm not convinced that this is the sole cause for any sort of mental health issue in our community. It's just an easy cop out for people.'*[319]

An Arab participant, Participant 8, agreed that this notion was apparent both in his country of origin and in the UK; though he was surprised that this attitude still existed in the UK. He stated;

'*Astonishingly, I found that still some people believe in djinn and magic things, and these things here in UK- this was something which is astonishing to myself, and we used to find some people who thought that they are touched, being touched by a djinn. So that they are like some djinn is controlling them or taking over them. And we would think that most of these cases could be some psychological issues that need a professional help.'*[320]

[318] Quote from Participant 12
[319] Quote from Participant 4
[320] Quote from Participant 8

The use of his phrasing "still some people" and "astonishing" conveys that the participant was shocked in a negative way that individuals ascribed djinn and "magic" to various issues they faced. Participants 4 and 8 both agreed that describing these issues as djinn were used as almost an excuse to deny legitimate mental health issues. Participant 4, who is of Pakistani origin, noted that djinn '*is a massive issue in Southeast Asian culture'*.[321] When asking participants who identified as Southeast Asian (Pakistani or Bengali), they all stated that it was an issue in their communities. Djinn is a factor of mental health in the Muslim community that is important for practitioners and anyone with an interest in the field to acknowledge. While there are debates about its legitimacy Islamically, amongst many Muslim cultures, djinn are believed to be a cause of mental illness.

Participant 6 and Participant 8, who are both of Arab backgrounds, agreed that the notion of djinn causing mental illness was more prominent within South Asian cultures. Participant 6 said,

> '*A lot more, like, Pakistanis will talk about it. You know… things like that apparently [are] more common in the Indo-Pak region. But when I- yeah, I didn't really get a lot of people talking about in [my Arab country].* '[322]

From what participants have stated, the idea that djinn cause mental illness, and the prominence of djinn is found more so within South Asian cultures than any other cultures interviewed. This may lead to worse uptake of secular or clinical mental health services because they may seek to solve issues through solely spiritual means. In the UK, the combinations of some views around djinn, stigma, lack of cultural competence in clinical settings, and the large wait times for mental health services contribute overall to a slow uptake of said services. As mentioned, djinns are a widely accepted belief within Muslim communities, but certain beliefs about djinn, and their connection to mental illness are often misunderstood within the Muslim community. So, while there exists debate culturally about what djinns are capable of, this does not mean that Muslims do not connect djinn with mental illness, in fact, quite the opposite.

Participant 9 stated that he had often heard of the idea of djinn within the context of mental illness, but always in a way that perceived djinn negatively.

[321] Quote from Participant 4
[322] Quote from Participant 6

> ‘*When I’ve heard it, it’s always been in a negative sense. It's never been a good, like in a serious discussion. I think… Every time I hear that I try and listen to what people say, but then I try and not listen to them at the same time. I think every time someone mentions that to me, they're trying to use that as an excuse to not be able to support or have a conversation around the issue of mental health. Rather they’re trying to use something else as their way of you know, that’s what it is, it’s not this or that. In reality, they do not know what they're talking about and that's the conversations I've had around that. And then I think it's not helpful at all, and it further stereotypes and stigmatises and put barriers in place for people who are actually suffering, who need help and want to have conversation.* ’[323]

What this participant has stated is extremely important. It emphasises the idea that many still will use the idea of djinn causing mental illness to not discuss mental health. By using this idea, they believe they are further stigmatising those who do need to seek help for mental ill health because it diminishes their suffering to a purely esoteric or spiritual one, rather than a legitimate medical problem.

Participant 6 noted the extent to which djinn can be blamed for illnesses, moving beyond mental health issues to include neurological disorders such as epilepsy. He said in response to a question about djinn:

> ‘*Even as far as some neurological illnesses, some people talk to me about, you know, like possibly epilepsy, some forms of it might be caused by djinn. I've not really explored that that much because I didn't really find much interest in it, but I've come across that before. Another thing is, if you stay away from Allah or you know you do not really like, pray as much or you do not read as much Qur’an or things like that, I think they will also affect wellbeing.* ’[324]

He also addressed the belief which appears often in the Muslim community, and many other religious communities: that mental illness, whether caused by djinn or not, is caused by not practising the faith enough. One example of this sentiment is believing a sufferer of mental ill health is not participating in prayer, one of the compulsory five pillars of the Islamic faith.

Participant 11 who is of mixed white and Arab ethnicity discussed what he had heard about the idea of djinn causing mental illness and djinn in general. He said that one of his lecturers in a university course, when discussing djinn noted that these ideas seemed to be more prevalent in South Asian backgrounds, arguing that they seem to congregate in certain

[323] Quote from Participant 9
[324] Quote from Participant 6

geographical areas, in this case, areas which may have a high Pakistani or Bangladeshi population.

> '*I'll keep names out of it, but like, I remember kind of talking about generally like this [lecturer] on my [university] course… He's kind of saying like, it's weird that all the like djinn seemed to like congregate around East London, right? …Well of course we do believe in it 'cause it is kind of like you know part of the- part of the faith, so kind of like [he] was gently reminding us [that] you have to believe in this.'*[325]

This further reinforces the notion that the idea of djinn and mental health is especially prominent within South Asian communities, although, as the participant mentioned above, djinn are a phenomenon which are part of the Islamic faith. This also suggests some confusion as to the known or unknown impact of djinn on an individual. What djinn are or are not capable of seems often dependent on cultural understanding, as shown through these discussions with my participants. This is a cultural and religious idea which mental health providers delivering care for the Muslim community should be aware.

Participant 14, a doctor, described his interaction when approached by the family of a patient who was speaking to a religious *faqih*, saying,[326]

> '*Her family spoke to us because she was speaking to a religious faqih, who was giving them advice but was basically taking advantage of them, saying "you need to give me this or that or I'll put a djinn on you." So, I think there was an element of mental health [issues], but she'd sought out this person to try and help it… but it was a case of someone being exploited.'*[327]

The issue of individuals being exploited in relation to mental health and djinn is something that was explored in the Literature Review section of this work. It is an important concern that practitioners should be aware of, in order to support victims, and to ensure others are not duped and abused by these individuals.

Views on Mental Ill Health

In addition to the idea that djinn caused mental ill health (a notion which my participants themselves had heard of, but not necessarily subscribe to), the idea of what causes mental ill

[325] Quote from Participant 11
[326] A faqih is an expert in Islamic jurisprudence and law.
[327] Quote from Participant 14

health produced a variety of opinions amongst my participants. Participant 3 believed that it was a mixture of medication, chemical/drug use, and trauma. Using the example of a family member who suffered from schizophrenia, he said,

> *'I've experienced mental illness as in not my own mental illness but with a [family member] of mine and he was diagnosed with schizophrenia, and he took medication and that medication has had an impact on how he- he's able to live his life. And just also in him personally, you know, his social interactions and the way that he thinks. And I mean, he seems convinced that it was triggered by cannabis use. So that would effectively be a chemical, you know, like a chemical imbalance; but knowing him, I know that there is- there's lots of issues. He said he has suffered trauma throughout his life, so the loss of his mother when he was young.'*[328]

For this participant, his form of reference for mental ill health was a comparably severe condition, schizophrenia; and in his view, this disorder has multiple causes. Participant 4 believed that genetics had the biggest part to play in the emergence of mental health conditions, saying,

> '*Having met people with mental health issues, I think maybe it's something psychological in their DNA because I know of people who have had mental health issues in the family. And these people have had issues in their family and then I wonder whether it's to do with their family dynamics and the things have gone on in that family, or whether it is genuinely something that's in their head that causes these problems. Stress and anxiety, I suppose it starts off with stress and anxiety and then it kind of snowballs into other issues.'*[329]

Participant 6 gave a more general opinion, stating that different conditions had different causes. He also discussed the impact of the pandemic, which at the time of the interview had been ongoing for approximately one year. Though we did not know the full extent of the pandemic by this point, the strictest lockdown measures were over, and the vaccine rollout was taking place. This participant also noted the impact of factors such as exam stress on his mental health. This correlates with the 2019 Muslim Youth Helpline report, with 41% of young Muslim men interviewed saying they had experienced exam stress.[330] Participant 6 said,

> '*Loneliness is a very big factor. More recently in COVID, that's going to make people more vulnerable. I think it's not going to maybe cause it [mental health conditions], but maybe make them more vulnerable. The stresses placed on today's society, people in general, you know career stresses. You know what sort of, like, you're expected to*

[328] Quote from Participant 3
[329] Quote from Participant 4
[330] Hekmoun et al., "Muslim Youth: What's The Issue?" 14.

> *do. Exams for us is I think is [a stressor]. Family stresses, family bereavement, things like this are big factors. I think things not working out as well. You know, not really passing an exam or like just feeling really anxious about an exam. I think these are all factors.'*[331]

Participant 7 also agreed with this, saying, '*I think it's multifactorial, likely some aspects of genetics to it.'*[332] Participant 6 also noted the impact of the COVID-19 pandemic, specifically in relation to loneliness. This topic will be explored further in the next section of this thesis, as COVID-19 seems to have a negative effect on many participants' mental health.

Participant 8 encapsulated the attitudes of the causes of mental health being multifaceted. He said,

> '*Mental illness is like body illness, something which is natural and normal and ordinary. It is not like shameful or so disgraceful, you know. It does not contradict imaan or our faith. It could be as a result of some changes in the brain secretions, some of the hormone changes in the body. So, it could need some medications to make the balance. It could be caused, because of a lot of bad feelings which are not treated or not expressed. A lot of shocks which are not handled when they happened. So, a lot of reasons could lead to mental illness.'*[333]

Generally, there seemed to be an acceptance amongst participants that the causes of mental ill health can differ and can be many. Through this, we can decipher that these Muslim men generally see mental illness can be seen as a legitimate illness.

The Impact of the COVID-19 Pandemic on Participants' Mental Health

The COVID-19 pandemic had an impact on so many individuals' mental health. This section will examine the particularities of the pandemic on Muslim men's mental health in south Wales. Some of those individuals interviewed were keyworkers, working in medical or other frontline positions during the pandemic. Many interviewed noticed the impact of external factors on their mental health, such as the experiences of bereavements, the lack of community, and the closure of mosques in addition to more internal factors such as the increased feelings of loneliness as a result of the pandemic. Ramadan in lockdown was a

[331] Quote from Participant 6
[332] Quote from Participant 7
[333] Quote from Participant 8

recurring factor that participants mentioned affected their mental health through not being able to celebrate with friends or family and not being able to access the mosque for things like community iftars or nightly prayers.

Participant 2 noted how much Ramadan during the 2020 lockdown negatively affected him.

> '*I found Ramadan difficult. I didn't realise how [much] 'cause I tend to be more at my most sociable in Ramadan. And I didn't realise how much I enjoyed that social aspect of Ramadan and I was stuck home. And I was basically just- I was just home working, and then also fasting. And yet this the second lockdown this winter one. Yeah, definitely probably got to me. Because they closed the gyms as well. Yeah, and then I tried jogging and it was cold and it was wet and I thought that's not happening. So then the outlets that are used in the other lockdowns, all my day to day life which was gone to the gym, having a routine of you know, doing the school runs and things like that when they were those were taken away from me. Then yes, I think it did have an adverse effect on my mental health. Not to the point where I thought I needed help or anything like that it was more one of those moments where every now and then you just got to take a deep breath and sort of recalibrate. You know what I mean.''*[334]

This participant spoke about the difficulties of not being able to be sociable during Ramadan, which in 2020 took place during the first lockdown, so the concept of a lockdown, and not being able to see friends and family was fairly new. Participant 2 also mentioned the impact of the second lockdown which took place in the colder autumn months of 2020. He noted that one of his regular outlets, the gyms, were shut, and he tried to replace this by exercising outside but was unable to because of the weather. Colder, darker weather conditions are usually linked to poorer mental health for conditions such as seasonal affective disorder. Additionally, this was the second long lockdown of the year, by the time it got to this point, the novelty of lockdowns and the 'we're all in this together' attitude had worn off.[335]

Participant 8 also discussed the impact of the pandemic and lockdown on his mental health, stating,

> '*Yeah, it increased the stress sometimes, because I found myself isolated, not able to do my work… the libraries are closed and I'm not doing my [work] because I do not have the resources that I can do it. I don't make any progression with my [work] and I'm away from my family, so I do not have- so I'm spending time here. Yeah, this was very stressing to me, to be honest… If we're talking about stress, yeah, for sure when [it's] Friday and do not go to the mosque, this will be very depressing. Because along my life, the whole of my life, I used to go to the mosque for the Friday prayer... The*

[334] Quote from Participant 2
[335] "Lockdown Diaries: 'It's like the Novelty Has Worn Off,'" *BBC News*, February 5, 2021, sec. Bristol, https://www.bbc.com/news/uk-england-bristol-55769764.

> *only few times [when] I didn't go to the mosque on Friday was I when I was very very ill, for example. So, when the Friday prayer comes and I do not go, I feel myself recalling such memories or I feel that something which is very big, is happening around. However- that I was advising [others] not to gather together for the prayer. I used to advise my family in [Arab country] even if the mosques are open. Do not go to the mosques, because Islam would ask [us] to save lives. However, still breaking such kind of routine has its impact on [me] personally and mental illness as well. '*[336]

This participant noticed the impact on himself particularly in relation to missing Friday prayers because of the lockdowns. Whilst he did acknowledge the importance of not attending the mosque during a pandemic in order to keep the community safe, even encouraging his family to pray at home, he felt that breaking the routine he has kept of attending Friday prayers since he was a small child had an effect on him. He wanted to emphasise that the only times in his life he had previously missed a Friday prayer was when he was very ill, and used the word "depressed" to describe how he felt about not being able to attend.

Participant 12 was a medical keyworker during the time of the COVID-19 pandemic, and he discussed the effect this experience had on his mental health. He described having to work as a medical professional during lockdown as similar to going to war.

> '*I was redeployed to frontline, cut off from family and friends. Facing death, really like come the first-time round? When I was being redeployed, you know how to shave my beard off. Uh, for the first time in like high level, 15 years or something. And that was a big moment for me. For me, my beard was an identity. It was always something that I, you know- that was part of my identity and that you know I'm like, OK, well, I had to do this for stuff that's OK. Let's get some other thing. I'd save people's lives and that's different. But the preparation for it was like going to war; like I cannot even tell you like- the hospitals had these huge training centres open and hundreds of people coming in and out hour after hour. Like how people get ready for war and then people who have not done medicine like 30-40 years coming back out of retirement. '*[337]

Not only did Participant 12 have to deal with the stresses around his work but he also described a loss of identity when having to meet health and safety requirements. Many Muslim men have beards as they feel it is an important part of the *Sunnah*. For Participant 12 to have to shave his beard off, as he said, for the first time in 15 years, was something

[336] Quote from Participant 8
[337] Quote from Participant 12

that was part of his identity that he had to lose in order to be able to work. Almost having to sacrifice his identity to save lives.

Combined with these stresses, Participant 12 also discussed how being on the frontline meant he was initially separated from his family within his house: '*I'd come home and the kids come running to me and then I could not do anything.* '[338] However, he and his family later decided that they did not want to be separated; and if something was to happen, they would rather it happen to all of them.

> '*We decided that it's better to die together. Or you know, if yeah, uh then that be separated for weeks and then, you know, I die or something like that. That's- that was a real fault, you know that was a real thing because many people were living separately. But my wife didn't want that either. She said, you know what? Just what's the point? 'cause something happens to me, you know. We want to be together as a family anyway and I think we made that decision that that was the case. So, when I was redeployed on the COVID wards, we stayed together but didn't see anyone else.* '[339]

It is quite a terrifying decision that this participant, and many other frontline workers, had to make, to potentially die together. Even more heart-breaking is how Participant 12 described his second redeployment to help COVID victims and its effects on his mental health. He said,

> '*But the second time I got redeployed, that was the biggest, I think, impact on my mental health because … Because that was when I was in the step-down ward for COVID and that's where I was given a quite a senior position and I was redeployed for I do not know, 5-6 weeks. And this is where people were sent to die basically. So people who had COVID were stepped down because they had nothing else that could be offered to them in intensive unit, and my God- like, just seeing people for weeks and then coming the next day to see if they had died. You know that was- Well, it's just- it still impacts me so much and like speaking to kids you know. Imagine speaking to a doctor on the phone asking how their father is, but you cannot come and see your father. So, you know, I spent hours with families crying to me on the phone. I'm telling them it'll be OK and it wasn't, and their parents and their father died.* '[340]

It was incredibly important to include this quote in its entirety to convey what these frontline workers went through; how death consumed their everyday lives, and how it affected their mental health.

[338] Quote from Participant 12
[339] Quote from Participant 12
[340] Quote from Participant 12

> *'I even remember one person you know, having discussion about- well, we should not resuscitate him because he was old. He had other risk factors, but he wanted to be resuscitated and just having that discussion was so difficult because the family was crying. They were upset with it… These sorts of things, you know, I could not turn off from and it still haunts me. I still remember number [of] the guy's bed let alone his face and his name'*[341]

This quote also reaffirms the massive impact that the pandemic had, particularly on medical staff. The mental health repercussions are something that we may be experiencing for a long time into the future. Participant 12 also noted the specific issues faced by the Muslim and ethnic minority communities during the pandemic, saying,

'*… and then also you know the fact that COVID is really targeting ethnic minorities and things and the that you still hear people dying from ethnic minorities by age, you know all of this had a big impact.'*[342]

There is further research yet to be completed regarding the impact of the pandemic on medical professionals and keyworkers. In regard to Muslim medical professionals and keyworkers, how this may have impacted, whether positively or negatively, the relationship with their faith.

Participant 14 was also a medical professional working in healthcare during the pandemic, and he shared his sentiments regarding his mental health during that time. This participant worked a lot to encourage ethnic minorities to take the COVID-19 vaccine.

> '*Because as you- as you're aware, that vaccine uptake [by] ethnic minorities was poor at one point, but we do a lot of stuff out of our own time and resource to try and get that addressed, which was good and successful. But obviously, it added more workload and more stress there. I was one of the people who, I was lucky in a way because I had to go to work, so I wasn't stuck at home. In the first lockdown where we could not see any family and things, so that was a little bit isolating in terms of, my family do not live far away, and we were kind of sort of going to end of the drive and just speaking to them from there.'*[343]

At the time of writing this thesis during 2022 and 2023, the COVID-19 pandemic is largely over as the vaccine rollout has been completed and we have not been subjected further lockdowns. However, we must acknowledge the massive impact of the pandemic on mental health. From my research asking participants about said impact, we can determine how

[341] Quote from Participant 12
[342] Quote from Participant 12
[343] Quote from Participant 14

Muslim men may use certain institutions, such as the mosque or the gym, to maintain positive mental health, and we can build mental health support into these institutions.

Jones-Ahmed examined experiences of British Muslims of Ramadan during the lockdown, drawing upon her PhD thesis of fieldwork completed in Ramadan 2020.[344] Many of her findings were similar to what my participants shared. Interestingly, she also noted that some of her participants found Ramadan during lockdown as a "blessing in disguise", with some of the Muslim mothers and wives noting it allowed their husbands to be around for Ramadan.[345] Jones-Ahmed detailed one of her participants, Hasina, saying, "if it's not lockdown, my husband and my son would sometimes go to the mosque right? For taraweeh, for maghrib, but in this Ramadan, we have to do it together*"*.[346] Jones-Ahmed noted that for many, lockdown had an "unexpected benefit of bringing families closer together through worship".[347] The men interviewed for my thesis rarely noted these benefits of the lockdown, mainly concentrating on the difficulties faced when unable to attend the mosque in Ramadan. It is more of a requirement of Muslim men than of Muslim women to attend the mosque, so it is understandable that these feelings of loss were apparent amongst men when speaking of the mosque in particular. We therefore cannot underestimate the important role that mosques play within the community and serve, almost unknowingly, as a protective factor for positive mental health.

Jones-Ahmed did discuss the positive opinions of some men as a result of lockdown, with one respondent saying they made an effort to have their home feel more like a mosque, or '"Muslim" space, and made it feel like Ramadan.[348] Some of the men I interviewed found the time during lockdown to be difficult, as shown in Participant 8's remark,

> '*When [it is] Friday and don't go to the mosque, this will be very depressing. Because along my life I- the whole of my life, I used to go to the mosque for the Friday jummah prayer. I lead the prayer. Sometimes the only few times which I didn't go to the most on Friday was I when I was VERY ill, for example. So, when the Friday prayer comes and I don't go, I feel myself recalling such memories or I feel that something which is very- is very big, is happening around.'*[349]

[344] Laura Jones-Ahmed, "Isolation, Community and Spirituality: British Muslim Experiences of Ramadan in Lockdown," *Religions* 13, no. 1 (January 2022): 74, https://doi.org/10.3390/rel13010074. Abstract.
[345] Ibid, 4.
[346] Ibid, 11.
[347] Ibid.
[348] Ibid.
[349] Quote from Participant 8

Similarly, Participant 5 echoed the sentiments in regard to mosques closing,

> '*[when the] mosques [are] open, you just go and just pray; but that is a very simple thing that can have an impact'.*[350]

The participant here was describing how something seemingly small such as the mosques closing could have a profound effect on an individual's mental health.

Barriers to Seeking Support

As theorised by Inayat and discussed in the literature review, six key factors exist which could be seen as barriers for Muslims wanting to access mental health services.[351] The below presents my findings based on Inayat's identification of six barriers. Though I did not necessarily ask participants about each barrier directly, I asked them generally, 'What would stop you accessing mental health support?'. Although Inayat wrote almost 16 years ago, many of the barriers still exist (both generally, and as evidenced within my research), suggesting there has not been much progress in regard to mental health access and support for Muslims.

1. Mistrust of Service Providers.

This was not found to a large extent in my research. This does not mean to say the mistrust of service providers does not exist. Participants in my research did not have a mistrust of service providers; rather they were not confident in the abilities of service providers to be culturally and religiously competent. Participant 1 stated,

> '*I think sometimes the difficulty is there's very few who I feel are competent and capable and understanding to the extent I need them to be. If I'm going for that kind of advice [counselling], I think I really need to feel absolute trust in the person and understanding and a sense of them knowing what I'm going through. And I think that partly comes back to where I was saying prior about sort of the unique situation [that] we're in'.*[352]

[350] Quote from Participant 5
[351] Inayat, "Islamophobia and the Therapeutic Dialogue." 289.
[352] Quote from Participant 1

In this instance, the participant was discussing the unique situation British Muslim men find themselves in, at the intersection of British or Welsh, Muslim and being a man, dealing with the issues that may arise from any of those identities.

2. Fear of Treatment.

This barrier is close to what I have found in my study. The fear of the unknown when it came to treatment for mental ill health was common with many participants. This closely ties in with the stigma surrounding Muslim men and mental ill health treatment. Some of the participants who had seen their GPs for their mental health noted a fear of treatment when it came to medication, and a reluctance to undertake it. Participant 3 said,

> '*So, I went to a- I went to a doctor to the local GP and sort some advice. And they suggested medication, which I didn't take... At the time I was also smoking a lot of weed, so that obviously I know is not helpful in in those situations and it can be a trigger for other responses as well. So, I just- I didn't take the advice of the doctors, such in in terms of medication, but they obviously- they said look, there's certain things that you have to address, and you know what in your life is making you unhappy. '*[353]

While Inayat expressed that a barrier is a fear of treatment, I think a pertinent solution to this could be integrated treatment; one that encompasses religion and spirituality. This is not only due to the emergence of faith-based counselling and Islamic psychotherapy in the UK, but also because many participants in my research stated the importance and comfort they found through spiritual means, such as attending the mosque, when going through difficult periods.

Furthermore, Participant 3 mentioned smoking weed during the time he sought his GP's advice for his mental health. According to Ali, some scholars 'made an analogy with alcohol to provide a basis by which to offer a legal ruling on drugs', i.e. to say that drugs are prohibited or *haram*.[354] Cannabis, or its Arabic term *ḥašīš,* has often been utilised and associated to Sufis, 'who employed it to help them meditate'.[355] The reasons why present-day Muslims may use cannabis to cope with stressors related to mental health must be further explored. There are a variety of opinions which exist in relation to whether cannabis, or various parts of the plant can help with mental ill health. However, research suggests that

[353] Quote from Participant 3
[354] Mansur Ali, 'Perspectives on Drug Addiction in Islamic History and Theology', *Religions* 5, no. 3 (September 2014): 912–28, https://doi.org/10.3390/rel5030912. 916.
[355] Ibid

there is a link between cannabis use and psychosis/schizophrenia, and that the chemical THC found in the plant is the main cause for this.[356] The use of CBD as a therapeutic method and positive effect on schizophrenia is showing potential.[357] Overall, this needs further research, particularly how drug use may also be linked to socio-economic backgrounds, and also on mental health.

Participant 4 noted that while he was going through the difficult period of a divorce, he found attending the *masjid* helped him, saying,

> '*I started, you know, I would make an effort to go to the Masjid and pray with the congregation, 'cause I felt much better for it. And comparing, you know, in comparison to other people's issues, they weren't big issues but they were issues that affect me. And. Looking back at it, you know I'm glad I that's the way I did deal with it.'*[358]

If mental health support services could understand that Muslims may want to seek help through these means, they could encourage mosque leaders to undertake mental health training in order to better help their congregations and perhaps to help encourage those for whom the mosque is not enough, to seek help through other means.

3. Fear of Racism and Discrimination.

This was not a barrier that participants discussed without prompting or asking directly, as opposed to factors such as stigma, pride, or emotional wellbeing. However, there were a few participants who did mention this barrier, but more so in regard to racism and Islamophobia having a direct impact on a participant's mental health, rather than a barrier to seeking support. Participant 9 stated that,

> '*I think [racism is] an issue where you do not understand it fully when you're growing up and in your teenage years. And you understand that it's not just about direct racism or direct Islamophobia. You know your experience on the street- someone calling you a name, someone saying things, but there are underlying causes as well.'*[359]

[356] Shweta Patel et al., 'The Association Between Cannabis Use and Schizophrenia: Causative or Curative? A Systematic Review', *Cureus* 12, no. 7 (21 July 2020): e9309, https://doi.org/10.7759/cureus.9309. 9.
[357] Ibid.
[358] Quote from Participant 4
[359] Quote from Participant 9

However, when Participant 9 was also asked what would stop them receiving mental health support, he said,

> '*Practically, just getting a GP appointment takes forever, so that that's a barrier… I think it would be my last choice.'*[360]

This suggests that the biggest barrier for this participant to seeking mental health support is practical means, which are shared by the wider population, and not necessarily specific to the Muslim men population. When asked directly whether ideas of racism and/or Islamophobia would have an impact on the participant's decision to seek help, Participant 9 stated:

> *'For me personally, I would not think of that as a barrier. I would not see that as an issue I think.'*[361]

Participant 13 agreed with Participant 9 that he did not think Islamophobia or racism from potential counsellors are a barrier for Muslim men to seek treatment for mental ill health, answering '*I do not think so, no.'*[362]

Though these participants did not feel that a fear of racism or discrimination was a barrier to seeking support, this does not mean this factor is non-existent.

4. Language Barriers.

As this study was conducted in English, and by virtue of participating in the interviews, participants could therefore speak English and a language barrier would not have been noticed. Following the first few interviews, I noticed that words were commonly being used in participants' cultural languages. While I expected words such as *salah* or *namaz* being used in place of "prayer", participants tended to use words referring to family members in their own languages. To ensure I did not disturb the interview flow, I pre-made family trees in commonly spoken languages for my own reference. This was an idea formed from memo-writing which enabled me to think about how I could make the interview process as easy as possible for participants.[363] This factor could be investigated further through research with

[360] Quote from Participant 9
[361] Quote from Participant 9
[362] Quote from Participant 13
[363] Tweed and Charmaz, "Grounded Theory Methods for Mental Health Practitioners." 132.

individuals who prefer to communicate in languages other than English. Though this study was completed in Wales, amongst Welsh Muslims, no participants wished to converse in Welsh. Had this had been preferred, I would have consulted with my supervisors to find the best way forward.

5. Differences in Communication

This was not apparent as an issue within my research. This may be because if an individual was to seek out an intervention such as talking therapy, they would understand the methods of communication involved. Participants did not mention differences in communication as a barrier to seeking mental health support. Though, as discussed in number 6, one participant mentioned how counselling may 'break the boundaries of privacy'.[364] In addition to this being a difference in culture, this may also be a difference in communication for Muslims.

6. Issues of Culture

Participant 5 discussed the issue of culture around seeking therapy, stating that talking to a counsellor or other support service could go against Islamic norms of hiding one's sins. He described counselling as similar to confession in the Catholic tradition and felt that this idea was too Western and perhaps could not mesh with Islamic norms.

> *'The Western approach to counselling is to be very open and, which I think breaks the boundaries of privacy. It's similar to Christianity like revealing your sins to the priest. I think that's what the Western culture unfortunately follows when it comes to counselling. With Islam, that's forbidden, we shouldn't reveal one sin to each other… That's the problem with [it and] Muslim men, you're digging [at] things that are hidden for a reason.* '[365]

This may be a reason why some Muslims will not engage with counselling services, and further research could be conducted on this topic. Participant 13 noted that he felt a lack of understanding of culture may prevent some Muslim men from seeking help about their mental health, saying,

[364] Quote from Participant 5
[365] Quote from Participant 5

> ‘*So, lack of cultural sensitivity and understanding, you could add that. For example, if I've got issues going on in my house and its Bangladeshi household, a white guy is not going to know my issues, or a non-Muslim is not going to know my issues either. Therefore, imams usually are the ones that people go to for, not mental health issues, but for problems; and so obviously part of the problems underlying mental health issues… But unfortunately, not all imams have the skills to deal with the mental health side of things.* ’[366]

He discussed that because Muslim men are used to speaking with an imam for any problem they may be facing, many also turn to imams for help with their mental health. Unfortunately, he said, many imams do not have the appropriate training or credentials to deal with mental health difficulties, especially regarding more severe conditions. To combat both the lack of training amongst imams, and the hesitation amongst Muslims to attend counselling services, it may be pertinent for imams to be formally trained in counselling. This is explored further in the Recommendations section of this thesis.

Participant 11 noted a benefit of talking to someone from a different religious background, saying:

> ‘*So, my partner is a Christian, yeah? We obviously have some pretty fundamental differences, there's a lot of things I would talk to her about, which I might find more difficult to talk to another Muslim about possibly. Because, like, a bit of distance in some ways helps like you know, feel like- Oh no, I'm going to be like get someone like call me heretic if like we were already kind of got that distance. Obviously like personal closeness or whatever.* ’[367]

This may suggest that some Muslim men find it is positive to speak to non-Muslims regarding their mental health, and that they fear judgement from a Muslim counsellor, saying that they may be called a “heretic” if they spoke about something which went against Islamic values. The participant felt that a “distance” in religion between them and the person they were speaking to about their mental health would be beneficial.

While many of Inayat’s barriers for Muslims seeking mental health support were relating to misunderstandings of culture and wanting a practitioner from the same background as yourself, Participant 11 appreciates the difference between themselves and the person they were discussing their mental health with, because they were free to discuss anything they needed without being judged.

[366] Quote from Participant 13
[367] Quote from Participant 11

Participant 11 also noted more secular reasons for not seeking mental health support, stating that waiting times to see someone for their mental health was more of a barrier to them than a factor such as their pride.

> '*Waiting lists, to be honest with you [is something that would stop me accessing mental health support]. Like, I'm very aware of the amount of time it took to [get] anything done around, like accessing mental health, lobbying services in the university, and thinking the university are probably not bad at it. So then trying to book appointments with GPs about it and just like- Yeah, sure in a few weeks like a few weeks. Yeah, dealing with them [is a] nightmare, so like that- that would actually, I'd say, much more than any other sense of like. Type things like personal pride or a big one.* '[368]

In addition to stigma being a barrier to seeking mental health support, Participant 6 noted that he did not feel he had the time to see someone about his mental health because of how difficult it is to get an appointment with an already busy medical practice. Though some may suggest the utilisation of private medical services, this may not be an option for many Muslims. As has been explored, Muslim communities in England and Wales have higher levels of deprivation and therefore may not be able to afford private healthcare, meaning NHS services, or other free services are the only resort.

> '*Maybe I just- I didn't have the time. Because of like, how busy clinics are and you know? I think there's a stigma to it as well. I do not really care about that, but there is in our culture in general [a stigma to that].* '[369]

Reasons such as these can only be improved on a governmental or institutional level to ensure mental health services, whether they be NHS funded or charities, are receiving adequate funding to deal with the mental ill health epidemic. Though this is not a quick change, it is a recommendation of this thesis to improve funding, wait times, and access to mental health services at the governmental level.

Participant 15 noted his experience having a non-Muslim counsellor. In this instance, it is less an issue of culture, but more of an issue of religion, or lack of understanding. He stated he saw a non-Muslim counsellor for one session, saying,

[368] Quote from Participant 11
[369] Quote from Participant 6

> '*I had a non-Muslim counsellor through my work. She was an older lady. Very lovely, very easy to speak with. The fact that she was a woman didn't make me feel uncomfortable speaking with her or trying to, you know, get some progress with her. But the fact that they were not Muslim made it very difficult for me.*'[370]

This participant felt that because their counsellor was not Muslim, she would not have been able to understand the intricacies of what he was going through, especially in relation to his faith.

> '*I was having my internal strife which was having an effect on my external condition and work in my daily life and it was very difficult to connect up in that counselling session, 'cause it was only one and I could feel the counsellor herself, she was lovely but she was frustrated because she could see there was a deeper layer to what was disturbing or bothering me and they couldn't pinpoint it. And at one point, I said to her something like look, do you know what's causing me a lot of anxiety and grief? … I feel like something that I need is leaving me. And she said, well, what could that be? And I said, I'll save that for another day, and then I never went back.*'[371]

For this participant, the fact that he felt unable to share his concerns relating to his internal strife and his faith meant he could not continue seeing this counsellor. Following this initial experience with a non-Muslim counsellor, he found a Muslim counsellor and had a better experience' particularly as his friends were able to share with him how to find a Muslim one. Interestingly, no participants who described looking for Muslim counsellors specified wanting them to be anything other than Muslim. They did not describe wanting any specific religious identity, for example Sunni or Shia, or from any school of thought. Perhaps this would be the case if Muslim counsellors were more commonplace.

> '*So, I went through- uh, there was a board you could find online. It's an accredited board of Muslim counsellors, and for me it was quite easy. I actually asked them because I had a good circle of Muslim friends. I did ask them, look, do any of you know someone who can? You know you- could you recommend anyone? And they were able to, which is quite nice.*'[372]

Here, there was less an issue of culture when it came to the client-counsellor relationship, but more so of religion and the feeling of a lack of religious literacy in terms of Islam on the part of the counsellor. While in this case the barrier was able to be overcome by the participant seeking and finding a Muslim counsellor, this is not always the case. Many

[370] Quote from Participant 15
[371] Quote from Participant 15
[372] Quote from Participant 15

individuals are unable to find a Muslim counsellor, and when they see a non-Muslim counsellor, the counsellor may not have an adequate understanding of Islam.

Participant 15 described the immense positive change he experienced through having a Muslim counsellor, saying,

> '*It just changed my life, and I feel that was the very first session I had, that was the point my life began to make sense again. So, the Muslim counsellor I sought out, he was- he's an imam of his masjid. He's formally trained in all of his counselling and psychotherapy, and he had an approach that was more, because in counselling, there's two ideas: one is, it's your relationship with the counsellor or therapist; or it's the techniques they use. And for me, in this instance, it was the relationship. It was like a therapeutic relationship, and he felt like a mind reader.* '[373]

He felt that having a counsellor who was both trained in Islamic ideas (in this instance, an imam), but who was also trained in psychotherapy, had a profound impact on him. He said,

> '*[It] gave me confidence and it helped me to understand and process both my, you could say, worldly emotions, how I feel about like my job and where I stand and those things, and my relationship with people and also processing, you could say my grievances and anxieties with Islam at the time as well.* '[374]

Though not necessarily mentioned explicitly as a barrier to seeking mental health support, Participant 16, who is a White convert to Islam, noted that whether he was seeing a Muslim counsellor or a non-Muslim counsellor, he feels he would have to explain aspects of his life, saying,

> '*So, I would kind of go in explaining OK, do you know what I mean? Unless it was you know, specifically you know, I mean- even if it was an Islamic counsellor, you know, if it was… somebody who was overtly Islamic, … I would then be explaining the other way round about how much [of] who I am and the pressures that I am are from who I was and where I was before.* '[375]

This shows a difficulty that someone who is a convert may face, having to explain issues from both themselves as a Muslim and when they were not. This individual did not clarify what he meant by "Islamic counsellor"; whether he meant a Muslim counsellor, or a counsellor who practices the field of Islamic counselling. We can infer from the next sentence that he means a Muslim counsellor, as he goes on to say that he would have to

[373] Quote from Participant 15
[374] Quote from Participant 15
[375] Quote from Participant 16

describe himself to someone who is Muslim or non-Muslim. “Islamic counsellor” is an interesting term used by this participant, perhaps inferring that he expects all Muslim counsellors to offer some kind of Islamic psychology kind of service.

Largely, there were mixed opinions from participants regarding issues of culture being a barrier to receiving mental health support. There was no definitive answer from participants overall about whether they would prefer to receive mental health support from a Muslim or non-Muslim practitioner. Therefore, as a recommendation, I would suggest that all practitioners are educated in Muslim mental health when they are working with Muslim clients, as an increased religious literacy may improve retention and outcomes for Muslim service users. One course designed by Cardiff University’s Islam U.K. Centre has been launched to educate practitioners on Muslim mental health.[376]

The Definition of What it Means to be a Man

The few questions asked to participants were intended to establish: what it means to be a man in their culture; and then what it means to be a man in Islam; and what it means to them to be a man. To analyse this, I will be theming the answers to this question by participants’ ethnicities: Pakistani/British or Pakistani, Bengali/British or Bengali, Arab/British or Arab, British/Welsh, Indian/Indian, Mixed, Somali, and Black African. There were also two participants who each identified themselves as “Asian” and “White”. Within this question about “culture”, many participants also spoke about Islam, suggesting the two are intertwined at times. I will then link the answers to this question to the question around if the roles and expectations placed on Muslim men have an impact on their mental health to note any differences between cultures.

Although I asked participants if they followed a particular Islamic school of thought, most just identified as Sunni, with one Ahmadiyya participant. Some of those identified further as Hanafi, Maliki, or Salafi for example, but generally no further than Sunni or Ahmadiyya. I am unsure if that is because they did not understand how to define their school of thought, or did not know it, or indeed whether they did not find it important. However, this means it

[376] “Understanding Muslim Mental Health,” Cardiff University, accessed February 25, 2023, https://www.cardiff.ac.uk/research/explore/find-a-project/view/2526559-supporting-mental-health-in-muslim-communities.

was fairly difficult for me to make conclusions on views of mental health or masculinity based on a school of thought, or perceived identity. Rather, I will make conclusions based on ethnic backgrounds. Broadly, many ethnicities will follow similar schools of thought, but may become more complicated when looking at Muslims of mixed backgrounds.

The below section of this thesis will examine participants' responses in regard to their cultural and ethnic backgrounds. Many of the interviewees from similar ethnic backgrounds gave related answers to questions, leading to the ability to base conclusions from these responses. The answers and commonalities can enable practitioners to better understand and cater to their Muslim clientele.

Pakistani/British Pakistani Participants

The five Pakistani participants all had a common denotation of what it means in their culture to be a man. Ideas around being a provider were common, as was the notion that the definition of what it means to be a Muslim man can change depending on the situation.

Participant 2, who is of Pakistani background, noted what he felt was the role of a man in Pakistani culture; but he discussed that there is a difference between what is expected of a Pakistani man in the UK compared with a Pakistani man in Pakistan,

> '*In the culture, I mean, it would be probably to provide for the family you make all the decisions pertaining to your family….t is, you know, shouty, be aggressive, dominant…If I was to look at Pakistanis, and I'm going to Pakistan [soon]. So it's a lot more. It's much stronger over there. Yeah, I just see their masculinity as dominating their own family members and whoever is more aggressive… But, so in this country, … play a little bit as well. OK, but yes, generally I would say, amongst the first generation, my parent's generation, definitely so. Amongst this second and third generation, I would say it's most definitely changing. And I do not really know at the moment it seems to be like… a case to case basis, but in the future I definitely see that changing it here in the UK. [I] do not think they'll ascribe to that interpretation of masculinity. I do not think that will be the case'.*[377]

Not only did he notice a difference between Pakistani men in the UK and Pakistan, but he also observed a change between different generations, noting that the views of masculinity that are currently ascribed to will not necessarily be the same in the future.

[377] Quote from Participant 2

In a similar vein, Participant 4 also noted that things were changing; that the current views of masculinity, especially those views in a marriage of a man being the one to go out to work and be the breadwinner while the woman stays at home and looks after the house or the children, are in transition.

> '*My dad's always been the breadwinner. My mum's always been at home looking after us and the house. Things have changed and whether that's changed culturally yet or not, or whether it's still going through a transition. I think men's roles are changing and will change and, maybe it is with living in Wales, maybe it is living within the UK, maybe it's not. I've not been to Pakistan for any length of time to see whether or not these changes have taken place there. But the roles certainly changed and I wouldn't say my role as a man in the relationship that I am in, is one of a breadwinner, it does seem to be, I'd like to say balancing out, but I think that's unfair because I don't think the way my mum and dad have had their relationship has been bad in anyway, it might be seen as old-fashioned but it worked for them.* '[378]

The way in which Participant 4 spoke around the ideas of being a financial provider came across as muddled. His thought process went between how his parents viewed this, and how him and his wife tackle and view these roles. This suggests a level of uncertainty with what is now expected of a man. Despite Participant 4's wife currently not working, he did not see himself as a breadwinner, but that the relationship was more balanced. It would be interesting for further research to interview couples together to obtain their thoughts on financial views in marriage. Participant 4 also mentioned the changing roles in British society, in addition to amongst Muslims, saying,

> *'Society, not just Islamic culture, but the wider culture, hasn't changed, and that is still prevalent in British society [referring to the idea of a man being the breadwinner], it's only just changing now and if you do hear of a man staying at home and looking after the child, it is seen to be something quite odd, but I think it is changing slowly. A lot of friends that I know that their wives do earn a lot more than them, so it makes sense for them to stay at home.* '[379]

As Participant 4 noted, men's roles are changing; and that even though within his family the norm is that the man is the breadwinner, he would be happy to stay at home to take care of the children. He added that this would partly be because he is becoming disillusioned with work. Furthermore, the participant uses the phrase 'Islamic culture', this may suggest a

[378] Quote from Participant 4
[379] Quote from Participant 4

marring of both Islam, and the participants' culture, where the participant sees both as one entity. The participant used the term 'Islamic culture' in response to the question "What is the role of a man in your culture and what do you think is expected of a man in your culture?'.

Similarly, Participant 5, who is also of Pakistani heritage, reiterated the idea that men are the providers both culturally and religiously.

> '*Man is a bread maker [sic]. A man is someone keeps a hold of the family, take care of the children. Someone who I believe should be emotionally aware, understand himself, understands his wife, understands his children. A man in both religion and culture. Someone who at least knows his religion, his obligatory knowledge at least. But also, is aware of society, and can protect his beloved ones.* '[380]

Participant 7 also stated that men are expected to be both a leader but also a breadwinner, a financial leader and provider for their family.

> '*Taking charge, you know, just being that dominant figure in and outside of the household. The main breadwinner. The one that's in charge of everything. Everything goes through him… I guess especially in our culture, things that normally would not be associated with [being a man], so even things small like you know skin care and the like. Just things like that just really aren't associated with masculinity per say, it's more just, you know, doing the dirty work, working, even as opposed to self-care.* '[381]

On a more superficial level, this participant also noted things that are and are not associated with masculinity such as skin care; suggesting that certain practices are inherently feminine, and others inherently masculine, in addition to a tendency towards admonishing anything that may be seen as feminine. Furthermore, this participant suggested that self-care is something that is not associated with masculinity in his culture. The use of self-care terminology by mental health services may therefore be something which puts off men from certain cultural backgrounds from seeking support.

Bengali/British Bengali Participants

[380] Quote from Participant 5
[381] Quote from Participant 7

Bengali or British Bengali participants constituted 2 participants within the study. One Bengali participant (Participant 1) commented on the intersectionality between masculinity, race, and age, as compared to his white counterparts. He stated,

> *'I think that pressure is very unique on this generation of young Muslim men because it's something quite unique to the scenario when you compare it to sort of white counterparts. They have the pressure of having to try and get on the market. The ladder of homeownership, all that stuff, that's all there; but generally, their parents are not only self-sufficient, they're able to help. They're able to provide some money or you know, at the very least, they can take care of themselves, and they have a retirement package and they have investments, you know. So much I think does fall on this current generation of Muslim men to be both able to provide for a future family or the young family and also their parents, and so it's kind of like you have to be successful.'*[382]

Muslim men, especially those who are second generation, are caught within a dichotomy between providing for both their past (in regard to their parents) and their future (their wife and children). Though this participant generalises the white community as having more generational wealth, it is difficult to not notice the poverty experienced by Pakistanis and Bengalis in the UK.

Participant 13 also described his ethnicity as Bangladeshi and noted a difference between the role of a man within his culture and within the Muslim community. As many participants from many cultures have said, Participant 13 spoke about how the role of a man in Islam compared with his culture was more fluid and less prescriptive. He said,

> *'From what I understand of Islam is it's not too prescriptive and it's very fluid and [it] gives guidelines, but it does not mean you have to follow them. It gives guidelines for you to adopt but it doesn't dictate culture on people. Like I said, it's just guidelines. So, for example, I could say, Islam says like the man is the protector and you know the breadwinner and this and that, but it doesn't. It allows for both a man and a woman to work. [It] even allows for if a man wants to be in the house and raise the kids, and the woman goes at work and breadwinner [sic]. It doesn't recommend it but it doesn't prohibit it and shun it. , I've heard a lot of these like talks with regards to like feminism and equality and I think people, people end up arguing over things which are very subjective and work differently to different people I think when we say yeah a man, should be like this and a woman should be like this, it's their opinion of what they think would work best. And so, they're not wrong, but they're not right either. It's very subjective and I think this is the beauty of Islam. It does not dictate to you what you should do.'*[383]

[382] Quote from Participant 1
[383] Quote from Participant 13

Although he spoke about how men in his culture were more expected to be the breadwinners and provide for the family, in Islam, he suggested these roles were not as clear cut, and it allows for fluidity in roles. However, these roles still exist, and Islam does not deny their presence. Participant 13 also acknowledged the impact of living in Britain on his ideas of what it meant to be a man.

> '*The people you're speaking to, are like Brits obviously, the context is we're living in 21st century Britain, and so obviously one of the demographic questions you asked was what's your ethnicity? And that does play a part and what generation immigrant are you? But in terms of my culture, the role of a man is a breadwinner, not so much doing the household chores, and a laisse-faire approach to the kids… If you say *my* culture, it's a mishmash of British and Bangladeshi. So, we have adopted kind of more a British way of living, if that even a thing. Because again, even Britain over the time has changed its culture of how a man is.* '[384]

Participant 13 felt that through living in Britain, both his Bangladeshi and British cultural influences had become intertwined. Many other participants felt the same way, though they further specified and expressed that living in Wales, more specifically than British culture, played a part in their views of masculinity. This idea is covered in more depth in another section of this thesis.

Arab/British Arab Participants

Though the term Arab encompasses a multitude of identities, I have used the more general term Arab so as not to identify participants. Though using their specific Arab identity on its own would not immediately identify participants, coupled with the data used, it may have given privacy concerns. Arab participants, similar to many others, focused on the role of a man in their culture to be responsible for their family. Participant 8, who is of Arab heritage said,

> '*[A man] is responsible for his family, this is what the cultural norms would [say], He should be the person who's going to be running the expenses of his house. He should be the person who is in control of his house with his wife and his children*. '[385]

Participant 6, a British Arab, agreed with this, saying,

[384] Quote from Participant 13
[385] Quote from Participant 8

> '*As a man, you are expected to provide for your family. You're provided to look after them, to be involved in your children's, upbringing… You're expected to support your parents, you're expected to support your wife and her family if they need anything. I think it's mainly a financial one, like a breadwinner role. But yeah, I'd say like that's a man's role, potentially. But yeah, I do not. I do not want to mix things that- there's other things involved. But like, yeah, as a man you want to be basically like supporting your family, like the backbone.'*[386]

From men of many cultural backgrounds interviewed, the idea of leading a family was prominent.

British/Welsh Indian/Indian Participants

Again, similar to many other participants, British/Welsh Indian/Indian participants regarded a man's predominant role in their culture to be that of a provider, often financially. Participant 14 who identified as Welsh Indian said,

> '*You're seen or expected to be this sort of pillar of strength and responsibility who'd provide for family. So, on a religious and the cultural side of things, like I said, look after parents and look after my family. My direct family, so obviously my wife and if we have kids, then the kids, and also be perhaps a little bit helpful for my brothers and sisters who need any help. I'm the eldest so that maybe changes things slightly as well. And also, to be there for parents if they need anything. So, there is a lot of responsibility and looking after people, and being that person who can do all those things. I suppose you kind of have to be that strong figure. I think either that's a cultural thing or a media thing that just as a man you have to be someone who is unaffected by things, and power on through things, quite stoic in their demeanour. But yes, that's rightly or wrongly, that's my view of it.'*[387]

Here, the participant also acknowledged the responsibility placed on him as the eldest child, and how this may incorporate what he feels his duties of a man are. This could be an element for future study, encompassing thoughts around eldest children as well as generational differences. Previous have shown that eldest children are assigned greater responsibility from a young age, and that this may impact them into adulthood.[388] This could also be studied in relation to its possible impact on an individual's mental health.

[386] Quote from Participant 6
[387] Quote from Participant 14
[388] Bruce Lackie, 'Learned Responsibility and Order of Birth: A Study of 1,577 Social Workers', *Smith College Studies in Social Work* 54, no. 2 (March 1984): 117–38, https://doi.org/10.1080/00377318409516582. 119.

This participant acknowledged the cultural views of what a man is and said they did not necessarily contradict his religious views. He felt that in his family personally, they are less culturally inclined and mainly adhere to religious values, saying,

> '*So, I think for me personally, the religious side does marry in with the cultural side. There are perhaps one or two things that [do]not contradict but perhaps a little extra in the cultural side that are specified outline in religion that you do.'*[389]

This begs the question on religion and culture, whether an individual can be totally sure of where religion starts and culture ends, and vice versa. This may be especially pertinent if that cultural upbringing has also been intertwined with their religious upbringing.

Mixed, and Mixed Race Participants

The participants which fall under the banner of "mixed" are not from the same racial backgrounds. Stating their exact backgrounds would present some confidentiality issues as many of these mixed ethnicities were fairly specific. However, it is interesting to see any differences in opinions due to the merging of different cultures. Four participants defined themselves as "Mixed" and this included mixes of Arab mixed heritage and Asian mixed heritage.

Participant 11 described himself as mixed White and Arab. In the final stage of the interview, when I asked him if he had anything else to add, he stated that he felt he was in a unique position as who does not, and has often not, lived in a Muslim area.

> '*Born in [Western country] we're the only Muslims for miles around'.* Later adding, *'I'm very aware of my experiences like a peripheral Muslim.'*[390]

The use of the word "peripheral" is interesting here, suggesting that the participant feels as though the is on the fringes or outskirts of the Muslim community, perhaps on the outside looking in. This participant noted that his mixed heritage influenced how he viewed the roles

[389] Quote from Participant 14
[390] Quote from Participant 11

and responsibilities of a man, as his ideas came from a mixture of his ethnicities, and as someone of Middle Eastern heritage living in a Western country.

> '*It's really kind of Western culture that's affecting me 'cause my experience of Arabic culture, Middle Eastern culture, has largely been the context of a Middle Easterner in the West. Yeah, it's not been like embedded in like the Middle East, and funnily enough, that thing I was talking about, like relaxed. Yeah, I would say actually like, … that I'm aware of a kind of like a kind of Arabic masculinity does tend to be one of much more quiet dignity than one of violence and [a] hyper macho man. See that I'm more used to seeing here. That might just be exposure. All the people I'm dealing with, like in my old uncles or whatever, but like yeah, my kind of male role models from my Middle Eastern family like, it's a very kind of genteel way of being masculine. That kind of like- I picked up there, and you said it's different to what you see here by what you see here.'*[391]

Participant 11 discussed how he viewed masculinity, differing from what many other participants had said. He spoke about the quiet and dignified way that many of his male family members express their masculinity, and that it differs from the idea of a "hyper macho man" that is often attributed to Arab men. He described the Middle Eastern men in his family, who live in the Middle East, as "genteel", and noted that was different to the ways in which masculinity is viewed by individuals in the West, saying he was comparing the ideas to a "White, Western kind of masculinity"[392].

Participant 15 viewed himself as Mixed, as mixed South Asian and White and as a third-generation immigrant, though he felt he was closer to his South Asian side. Much of his answer to what his view of masculinity in his culture was, was very mixed, intertwined with the religious view, but he said of the view of a man in his culture, that,

> '*Men [from my south Asian culture] and their worldview and mindset, I would say probably depends on a few factors, which is economic background and religious upbringing. Personally, what I've seen, a lot of men [from my south Asian culture] are very, very focused purely on finances, and very worldly things, that's what I've noticed., I have seen a lot of men [from my south Asian culture] who, …do have reverence for Islam, and they do follow Islam. But I have unfortunately noticed even men that are quite practising, you will see them in the masjid, and they pray and they're known, but they don't always put the sharia at the forefront of what they do. They do not always practise Islamic etiquettes and principles and honesty, truthfulness. I'm not painting one everyone with the same brush, but that's personally what I've noticed. For a lot of men [from my south Asian culture], if that is*

[391] Quote from Participant 11
[392] Quote from Participant 11

predominantly what they see themselves as is [south Asian culture], they may not always put the Islamic principles and character traits at the forefront.'[393]

Participant 18 identified as Mixed and is mixed of two different Asian heritages. He felt it was difficult to fully differentiate between culture and religion, saying,

'*Yeah, it's quite blurred, the line. But I think, in culture, I think to be financially stable, stable at everything really. Being able to take care of myself and then eventually take care of someone else's daughter. Being educationally/academically inclined, degrees and stuff. I think that's priority in my culture. Even before marriage, my parents will be like, "focus on your studies." So have a good degree, have a good job, get good money, get married, that's the narrative. In terms of being a man in Islam, I do not think I was taught this, but I think what I believe, I want to achieve as a Muslim man is to have a spirituality close, trust in God to go through life basically. And I think like if I have that level of spirituality that I can trust, then everything comes easy. It's what my idea of like, [a] calm good man in Islam. Yeah, just calm. I think calm is the word.'*[394]

He highlighted, as others did, that the main role or responsibility for a man in his culture, was to focus on being able to be financially comfortable, to have success in being able to provide for a future wife. For his role as a Muslim man, he spoke about the importance of being close to God. The participant responded with this from a question asking if what it means to be a man in his culture, and a Muslim man are different. Interestingly, he felt the line between the two were blurred.

Participant 21 is also of Mixed background, but he is a mix of many different heritages. He said, for that reason, he finds it difficult to define his culture and to identify with one aspect of himself more than others. He said,

'*I personally do not know how to associate to a culture because I am so mixed. It's not like I'm white and one other thing. I'm white and so many other things, so I find it really difficult. I can't associate with a specific culture.'*[395]

He added that he did not feel that there was an idea of masculinity put onto him through his cultural background, saying,

'*I do not think it was ever imposed on me. I do not think there was ever a level of masculinity that was imposed on me, or I was never treated differently culturally.'*[396]

[393] Quote from Participant 15
[394] Quote from Participant 18
[395] Quote from Participant 21
[396] Quote from Participant 21

This participant felt that any notions he may have surrounding masculinity, were not as a result of his cultural backgrounds, because cultural ideals of masculinity were not put unto him.

Somali and Black African Participants

Despite south Wales, and Cardiff in particular, having a large and historic Somali population, only two participants interviewed defined themselves as Somali. Those who defined themselves as Somali may also have chosen to represent themselves as Black African.

Participant 10 who identified himself as Black African stated that in his view, the role of a man in his culture was,

> '*My impression if you like, understanding of Muslim male figure in Islam is, look out for his family, to provide for his family, his wife and his children. Be the breadwinner where possible. Alleviate the pressures facing the house… And [to] lead by example.* '[397]

This answer was given as a response to the question "In your culture specifically, what do you think is the role of a man and what is expected of a man?". In this question, I specifically enquired about the participant's cultural expectations. However, he answered by sharing the role of a Muslim man. This suggests the blurring of lines between culture and religion in this participant's thoughts, with his first thought about his culture, being the way in which he practices his religion. The reiteration there again of being a financial provider and stating that a woman does not have to work should she choose that. This participant marred the views of religion and culture, suggesting that for someone of his background, perhaps they cannot be separated. This is similar to how Participant 4 responded to a question about his culture, he answered regarding religion. Again, this suggests that for some Muslims, there as a marring of the two concepts, and a difficulty in ability to separate the two.

One Somali participant, Participant 17, who identified as both African and Somali, noted that the main difference between religion and his culture for the role of men was when it came to who one was allowed to marry. He said,

[397] Quote from Participant 10

> '*They [religion and culture] are kind of the same thing, but obviously when it comes to marriage and all that, you got to marry your culture. Some people like some families, if you're Somali, which I am, some families will prefer you to marry a Somali girl or a Somali man, but ideally that is not Islam. Islam is [that] you can marry in Islam a Muslim and a male can even a non-Muslim.* '[398]

Participant 19 also identified as Somali, and he also felt there was not much difference in the roles and responsibilities of a man in both culture and religion, saying,

> '*I would say more or less the same: kind of expected to provide for the family. Just take care of everyone.* '[399]

The emphasis again here on the financial pressures of Muslim men and the need for them to be monetary providers. The impact of a Muslim man being the predominant financial provider is one which may worsen as a result of the Cost-of-Living Crisis. The consequences of this are explored later in this thesis.

White Participant

One participant identified as White. This participant was also the oldest of all participants and the only one to be in his 50s. He felt that his cultural background was extremely mixed as a result of living in many different countries and has merged with many different cultures as a result. Therefore, he could not define what he felt his culture exactly was. He spoke about the differences between the views of men and women in the UK, and in another English-speaking country in which he lived.

> '*In the UK I had come. you know the people that I mixed with in the UK…had a very kind of enlightened view of the role of men and women. And that's my kind of family view. And, but obviously when I was living in places like [redacted] etc. You know there was a much more kind of distinct male female role kind of thing, but it wasn't something that- that I took on board.* '[400]

[398] Quote from Participant 17
[399] Quote from Participant 19
[400] Quote from Participant 16

He felt that although he noticed these views in the different communities, he felt that the UK had a more enlightened view than the country in which he grew up and stated that view was more in line with his personal and familial beliefs.

Summary of Ethnicities

As predicted, there were not vast differences in the views of masculinity between different cultural backgrounds. There was however a noticeable difference in certain views of mental health, especially in regard to djinn. Participants noted that the notion that djinn are a cause of mental ill health were most prominent in south Asian communities, and this was something noticed by participants of other ethnicities and backgrounds as well.

As this research was conducted in Wales, it is important to acknowledge the impact of living in Wales on these participants' views, especially as individuals' experiences may differ to people living in England or other areas of the UK. Many said that living and/or growing up in Wales impacted the way they think about certain issues regarding culture, because south Wales is a multicultural environment with Muslims from so many different cultures. This will be explored further in the discussion section of this thesis.

Broadly, each participant from the respective ethnicities followed similar schools of thought. For example, Somali participants mainly followed the *Shafi'* madhab, and South Asian participants mainly followed the *Hanafi* madhab. This made cultural distinctions even more apparent. But can opinions, therefore, be put down to cultural background, or can they be put down to the madhab they follow? That does not mean that cultural backgrounds are redundant, as their culture may inform their opinions more especially when they believe there is a bigger distinction between what culture says and what religion says. For further research, a study could be conducted into the differences between cultural interpretations in comparison to following a particular madhab. Some participants were not sure whether or not they adhered to a certain madhab. There is scope for further research in the understandings of madhab, or Islamic terminology more broadly amongst Muslims in Wales.

Change and Development within the Muslim Community

Many participants noted that change is occurring; that future generations will not only be more open when speaking about mental illness, but additionally when defining what it means to be a Muslim man in the UK. Participant 1 stated:

> '*I think because of … the very complex backgrounds of Muslims in Britain, So Bengali, Pakistani Arab, Middle Eastern, [and] converts increasingly as well. Children from mixed race backgrounds. I think all of that means sort of we are writing our social environment as it goes, we're literally authoring it.'*[401]

This participant discussed that ideas and experiences of Muslims in Britain were changing because of the increase of interracial and intercultural marriages between Muslims, resulting in more children from mixed race backgrounds. These children would grow up to be between cultures, as this participant said, "authoring" their social environment and adapting to their cultural mixes. Nazroo et al., argue that existing literature shows that mixed race children both in the USA and the UK are "more likely to experience poor socioemotional wellbeing", as they may struggle with issues related to their mixed identity and being between cultures.[402] Udry et al., studied the health risks of mixed race adolescents in the USA found that those 'who identify [with] more than one race are at higher health and behaviour risks when compared with those who identify with one race only'.[403] Further research may be needed to understand these patterns, and the reasons behind them, as Nazroo et al., suggest this is unrelated to socioeconomic factors.[404] In Wales the population of those who identified as "Mixed" or "Multiple ethnic groups" in the 2021 census was 1.6%, and this has been increasing year on year.[405]

Participant 2 agreed that things are changing; especially in regard to what it means to be a man, saying,

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[401] Quote from Participant 1
[402] James Nazroo et al., "Socioemotional Wellbeing of Mixed Race/Ethnicity Children in the UK and US: Patterns and Mechanisms," *SSM - Population Health* 5 (June 22, 2018): 147–59, https://doi.org/10.1016/j.ssmph.2018.06.010. 147.
[403] J. Richard Udry, Rose Maria Li, and Janet Hendrickson-Smith, 'Health and Behavior Risks of Adolescents with Mixed-Race Identity', *American Journal of Public Health* 93, no. 11 (November 2003): 1865–70, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448064/. 1869.
[404] Nazroo et al., "Socioemotional Wellbeing of Mixed Race/Ethnicity Children". 152.
[405] "Ethnic Group, National Identity, Language and Religion in Wales (Census 2021)."

> '*Amongst this second and third generation, I would say it's most definitely changing. And I do not really know. At the moment it seems to be like a case on case-to-case basis, but in the future, I definitely see that changing it here in the UK. [I] do not think they'll ascribe to that interpretation of masculinity.'*[406]

The participant was here referring to the type of masculinity he believed was prevalent in Pakistani culture, which he defined as '*shouty,* [to] *be aggressive, dominant'.* He believes that this mindset is changing.

Participant 1 also noted the importance of Muslim men themselves playing the biggest role in changing perceptions around mental health in the Muslim community; the more people who speak out leads to wider acceptance from communities.

> '*I think probably Muslim men have the biggest role to play around the stigma of mental health and Muslim men, you know. I think the expectations and pressures [going to] come regardless… I do not think the case will be that … the wider community becomes more accepting or Muslim communities in general become more accepting and then eventually people start speaking. I think it's the other way around. I think it takes a few individuals to have the courage to kind of start breaking taboo to be prominent figures who do speak about it. And that I think takes one more step closer towards being comfortable speaking about mental health as a normal dimension of their self and human self that you know is absolutely common and part of it.'*[407]

This participant is of the opinion that it would take a few individuals to begin to speak out about their mental health in order to break stigmas surrounding the topic. However, as mental ill health is an epidemic which is showing no signs of slowing down, it may not be possible to simply wait until individuals are able to speak out. According to an article in 2023 by The Guardian, police in England and Wales are 'dealing with more mental health crises than ever'.[408] For the police to be involved with someone's mental health, there must be a need under the Mental Health Act; meaning this person's mental health poses a risk to themselves or others.[409] The increase of incidents reaching this point suggests that early interventions such as accessing counselling or NHS support are failing. Therefore, in addition to people

[406] Quote from Participant 2
[407] Quote from Participant 1
[408] Rajeev Syal and Rajeev Syal Home affairs editor, "Police in England and Wales Dealing with More Mental Health Crises than Ever," *The Guardian*, February 21, 2023, sec. UK news, https://www.theguardian.com/uk-news/2023/feb/21/mental-health-crises-police-england-and-wales.
[409] Ibid.

beginning to speak out about their mental ill health, other interventions such as community initiatives are needed to increase support for those suffering.

Participant 6 discussed how he thought there was the potential in the West for ideas around mental health and mental illness to change. It is interesting that this participant, and others assume the 'West' as one singular entity; an echo of the idea presented in *Orientalism* of the dichotomy between the Orient and the Occident. This is an idea which was emphasised by other participants: feeling that the stigma around mental health in the West and in Muslim communities is changing for the better.

> *'But yeah, there's a lot of clinics out there, you know and from what I've heard like this the social culture is changing. More guys are like you know outgoing and going to gyms and things like that. So, I think [Arab country] is becoming a bit more Westernised, and I think maybe the views on mental health will change as well potentially. ... [In the UK] if you say like I'm anxious or something like that, you know it's basically it would be expected to go down the Islamic pathway of just you know remembering Allah and that would help. That would definitely help. But in terms of like, these sort of services or these sort of mental health support networks, I do not think that would be explored as much by Muslim men or with the Muslim community.* '[410]

In this instance, Participant 6 felt that with the changing attitudes towards mental health, this may allow more Muslim men to not only seek help through Islamic or religious means, but also through more secular, psychological means or seek medical attention when needed. He discussed how the Islamic pathway of "remembering Allah" would help. Here, the participant may be referring to *dhikr*, an act of devotion where the worshipper repeats names of Allah or His praises. This often will be a form of comfort to a Muslim. He also spoke about doctors within the Muslim community who would be able to discuss both the Islamic and psychological effects and solutions to mental ill health. This reinforces a need for both an increase of Muslims in communities to be trained and educated on mental illness, but also for practitioners to be trained in Islam and Muslims.

Conclusion of the Data Chapter

[410] Quote from Participant 6

This chapter began with a reflection of the interviews. Leading on from the Methodology chapter, it was important to address the interview process and how this may have affected the topics which were covered and the organisation of the data. The Reflection of Interviews section gave an overview of the participants key demographics including ages and ethnicities.

This chapter has summarised the themes which emerged from the interviews with participants.

One theme discussed was djinn and their relationship to mental ill health. Again, this topic emerged as a point of interest following the literature review. This topic also became intersectional in regard to participants' ethnic backgrounds. It has examined these with reference to the themes in the earlier Literature Review chapter. It evaluated Inayat's barriers to seeking mental health support against barriers expressed by the participants.[411] Inayat's barrier which was found to be most apparent from my research was Issues of Culture. As discussed, some participants marred culture and religion but spoke about cultural ideals of masculinity as one which would disapprove of seeking mental health support. Fear of Treatment was also a barrier evidenced in my interviews, often to do with the fear of the unknown about what treatment for mental ill health would look like. The recommendation section of this thesis discusses how this may be combatted, and how to encourage mental health education within the Muslim community.

The Data chapter also examined participants' views on masculinity, specifically in relation to their faith and/or cultural backgrounds, and how this may link to wider theories within the field of masculinity. It divided the answers to this question by participants' self-identified ethnicities to determine similarities and differences between these groups. These ideas will be further explored in greater detail within the Discussion chapter.

The chapter discussed participants' views on mental health. Namely, what participants felt caused mental illness and how they viewed mental illness. This also related to the role of stigma and whether they may seek support for mental ill health. As we know, stigma is often a barrier for seeking support, and if individuals do not believe that mental illness is a

[411] Inayat, "Islamophobia and the Therapeutic Dialogue."

legitimate medical issue (rather than a spiritual one), this also may prevent them from seeking support.

This chapter ended with a summation of the change and development in the Muslim community around discussions of mental health and mental illness. Many participants spoke about their feelings that there were positive changes being made towards how mental health and mental illness are spoken about within Muslim communities.

The following chapter, the Discussion chapter, will examine in greater detail the key themes of this thesis in addition to the impact of this thesis, scope for further research, and recommendations for practitioners and communities.

CHAPTER 5 – DISCUSSION

This chapter will evaluate this thesis's main research question of:

"What is the impact of Islam and Muslim identity on experiences of mental ill health among Muslim men in south Wales?"

This question will be looked at through the lens of theories of masculinity. It will make the case that due to their demographic characteristics such as their ethnic backgrounds or age, Muslim men have differing views and experiences of mental ill health. Additionally, their views and experiences are impacted by their perceived notions of masculinity, which is influenced by their background. This theory was established through the use of Grounded Theory. Though I considered the utilisation of other theories, particularly those related to mental health, I determined that theories of masculinity corresponded the best to my study because it follows a sociological approach. Had I opted to use theories of mental health, I would have had to gain a better understanding of psychology and psychological theories and would not have been able to do them justice, as I am trained in sociological methods. Though the Data chapter has outlined many of the themes which emerged from the interviews with my participants, the Discussion chapter will deliberate the impact of these themes, and how the results may fit with existing notions on the ideas of mental health, masculinity, and Muslim men.

This chapter will end by providing recommendations from this thesis for communities and practitioners on how to improve outcomes for Muslim men using mental health services in addition to how to increase their engagement with those services more generally. This section will also offer policy recommendations for statutory organisation to support Muslim men's mental health services and initiatives but also to work on preventing mental illness from developing into a severe illness.

Theories of Masculinity and their application

It is important to examine theories of masculinity in relation to my primary research question as stated above, to establish how Muslim men may think about the topic, and how this may impact their views on mental health. For example, if a Muslim man believes that in order to be masculine, one must be X, but X negatively affects their mental health, then we can determine a causation. Unfortunately, to establish what a Muslim man's view of masculinity is, it is not as straightforward as a textual analysis of the Qur'an or Sunnah. This is because cultural backgrounds may implicate or change an individual's interpretation of what is the Islamic ideal. This is an idea which we have already uncovered within the Data section of this thesis by outlining the answers from participants based on their cultural and ethnic backgrounds on what they believe it means to be a man.

One important theorist in the field of masculinity is R.W. Connell whose book *Masculinities* covers a wide range of ideas. Masculinity theory has taken many forms throughout history, from Freud and his ideas of Oedipal repression to sex-role theory. Connell argues that due to men studying masculinity, this knowledge is "ethically compromised".[412] Therefore, one could argue that as a woman studying men, it is less so. Initially, the idea of sex-role theory seemed to be the most appropriate lens to analyse Muslim men's mental health. It fits with the idea that Muslim men are less likely to seek help or discuss their emotions in relation to mental health. They may see it as more of a feminine, or *jamal* thing to do, and not within the confines of their masculine roles.

Connell defined the most common approach of sex-role theory as:

> '*being a man or woman means enacting a general set of expectations which are attached to one's sex – the "sex role". In this approach there are always two sex roles in any cultural context, a male one and a female one. Masculinity and femininity are quite easily interpreted as internalized sex roles, the products of social learning or "socialization".* '[413]

Connell then goes on to note that gender can be reduced from these sex roles and are as a result of the 'differentiation of functions in social groups.'[414] This theory relies on sex roles that are well-defined, and clearly differentiated, something which is becoming increasingly uncommon in the 21st century where women are undertaking traditionally masculine roles and vice versa. By comparison, these roles seemed to not only be apparent to participants

[412] Connell, *Masculinities*, 7.
[413] Ibid, 22.
[414] Ibid.

when describing the roles and responsibilities of *Muslim* men, as well as the roles and responsibilities of men in their respective cultures.

I can apply what previous theorists have said about masculinity into my results of Muslim men talking about mental health. Most of the men interviewed ascribed to the notions of sex-role theory; that men and women are subjected to the set of expectations as a result of their gender and informed by their cultural backgrounds.

Participant 12 suggested,

> '*I think there's certainly some overlaps. There's certain some overlaps in terms of what I think Islam requires of a man, but the problem I find is that culture has abused that trust certain extent so that morality and the ethics behind that has been lost. Yeah, whereas I think it's been subverted where I think you know. I think man has always been a servant from Islamic point of view to the family. But it's a subverted to be dictatorship or. Uhm, uh, I was free to sit, but sometimes you know even it can be a bit oppressive in terms of how you know a man can be or expect it to be. You know it, you know. But I didn't get away. It's sometimes renders many useless in certain ways. That cultural approach things so they're just unable to look after themselves completely, and I've just seen the case over and over again where the woman on the house they will die of hunger, and they won't be able to clean look after things, simple things like that. Which is, you know, which is not what the ethics or the morality behind that is at all. But that's a very cultural understanding of you, know that that that you know if a guy gets married, he's going to bring in the money. Then the wife is going to look after the home he's going to come home. Who's ready that sort of thing? Nothing that that's obviously not wrong, but that's just cultural expectation.* '[415]

This participant suggests that even though there is a differentiation between Islamic and cultural views of masculinity and masculine roles, there is an overlap. As a consequence of how intertwined Islam and culture are, many may not be able to separate.

Participant 1 added to this, describing the ideas of what it means to be a man within his Bangladeshi culture, saying,

> '*I think stoicism is really quite an important aspect of how Bangladeshis approach difficulties. This is probably true for men and women, but definitely true for men, I think. And I think as well in a Bengali kind of idea of masculinity, [there's] touch of, I do not want to say anger, but, sort I find it interesting, just thinking about my parents.* '[416]

[415] Quote from Participant 12
[416] Quote from Participant 1

This participant also associated the ideas of Bengali masculinity to his parents, rather than one which he ascribed to himself. In this instance, his parents were first generation immigrants to the UK. Therefore, this differentiation between generations suggests a changing narrative in the views of masculinity. Perales et al., in their study of generational masculinities, found that with "fathers for whom religion was important to their lives [they] were more likely to pass on their masculinity onto their sons".[417] The inter and intra generational ideas of masculinity could be a pertinent idea for further study; intertwining this with ideas of race and culture.

If individuals have the view that a man is or must be a certain way, in this case, stoic, then these ideas would come with a negative effect on their mental health. For example, they do not talk about their issues, nor does it seem they have anyone to talk to about their problems. It appears to be a revolving circle, where having someone to talk to would enable them to improve their mental health, but the issue is knowing where to start. This is the reason why it is important to explore these notions of masculinity, as on the surface they may not seem to have connections to the impact of mental health and mental ill health, but as I have proved through this work, they are linked.

Many believe that as part of sex-role theory, the roles that Muslim men ascribe to are that of stoicism, hiding emotions but also to be a breadwinner. This differs from what the Islamic examples of masculinity are, with Participant 1 saying,

> '*I think speaking now much more open in terms of what I think a Muslim man is and should be, I think our examples of manhood and masculinity are very varied. In terms of the examples of, …you know, celebrated historical Muslims. But also, we have a very different conception, I think, of what masculinity looks like through the prophets and the Prophet Muhammad (saw) amongst them. I think some of the things that always strike me, for example (and this is something I think is really quite important) is gentleness and softness in a really important attribute of men; Islamically, of men that Allah has spoken highly about. So, you know, the Prophet (saw) in the Quran is described as being kind-hearted, soft-hearted and you know if he wasn't then people would've fled from him.* '[418]

[417] Francisco Perales et al., "Like Father, Like Son: Empirical Insights into the Intergenerational Continuity of Masculinity Ideology", *Sex Roles* 88, no. 9 (1 May 2023): 399–412, https://doi.org/10.1007/s11199-023-01364-y. 408.
[418] Quote from Participant 1

He describes the ultimate role model for Muslim men being the Prophet Muhammad and says that there are examples from the Prophet's life that differ from what is often thought as being a man in cultural masculinities. He specifically speaks about the Prophet's example of being "kind-hearted" and "soft-hearted", particularly as a method of encouraging people to the religion and notes that this should be an example for Muslim men. Again, these softer attributes seem to be less associated with cultural masculinities, and only more apparent within Islamic examples of masculinities. However, the examples of the former are perpetuated more than the examples of the latter.

More has been written on secular masculinity in comparison to Islamic masculinity. Islamic masculinity here means the exploration of examples of masculinity within the faith itself, and the ideas which stem from the Qur'an and Sunnah. Less is written on theories of masculinity of British Muslim men; therefore, I have constructed an argument based on pieces from many theories and applying it within my own context. Similarly, only sporadic research has been published on the sociological ideas and implications of masculinity amongst Muslim men.[419] I am therefore adding to this discourse of sociological perspectives by including mental health through the lens of masculinities.

In this work, I examine which theory of masculinity to which I felt that Muslim men ascribe. Though my research asked Muslim men what they felt is the role of a man/men, we can still assume the subscription sex-role theory even if they did not discuss the role of women explicitly. The roles that they did describe of a man were seen to be in balance or opposing to the role of a woman. Several participants felt that the role of a Muslim man was to be a breadwinner or financial provider, and to lead their family or community. Though many interviewees acknowledged that the role of a breadwinner was more prevalent culturally than religiously, the cultural expectation to prescribe to this notion was still there, and as evidenced, some participants marred the two. The idea of a man being a leader within his home or community came up during interviews with participants, though often they would not elaborate on the characteristics of a leader.

[419] Zahra Ayubi, "De-Universalising Male Normativity: Feminist Methodologies for Studying Masculinity in Premodern Islamic Ethics Texts," *Journal of Islamic Ethics* 4, no. 1–2 (December 15, 2020): 66–97, https://doi.org/10.1163/24685542-12340044. 68.

The financial aspect of this leadership was often brought up, especially in relation to the negative effects on their mental health. The consequences of the role of a man taking on increased burdens, including financial and emotional, often on behalf of their entire family, have an impact on stress levels and therefore on mental health.

While sex-role theory does fit with my research, I think there is a need for a new, developed theory of Muslim masculinities, based on the realistic convergence of culture and religion. While there is an existence of the field of Islamic masculinities, I do not think that this works in practicality, as one cannot necessarily separate ideas of religion and culture in this instance. It would be more pertinent to examine a theory of Muslim masculinities as a makeup of components of the many characteristics which make up a Muslim man, and most notably cultural background. This concept of background seems to have had the most impact on a Muslim man's views and experiences of mental ill health.

These roles of a man existing under sex-role theory may indicate barriers to seeking support. For Muslim men, I would add another barrier to Inayat's list, which could be linked to an Issue of Culture, but could also sit separately. This would be the issue of Fear of Weakness. If we ascribe to the ideas of masculinity found in *jalal*, or indeed within sex-role theory, vulnerability or weaknesses are seen as associated with seeking mental health support while also being associated with femininity. Therefore, these issues sit outside the roles of masculinity and may make men reluctant to seek mental health support. Participant 2 discussed this idea by saying:

> '*So, I thought about sort of therapy. I understand I do not really like opening up. It makes the feeling I feel was initially of weakness of vulnerability. I didn't like that feeling.* '[420]

Participant 13 also acknowledged this idea by saying,

> '*Like I said before, like men do not want to like really go into their emotions and how they feel and so, if that's like a natural inbuilt trait of a man, then that's a barrier for them to then go and access the mental health services.* '[421]

This participant ascribed to the idea that perhaps it's an inherent trait of men and masculinity that they do not want to discuss their emotions. However, as mentioned in sex-role theory,

[420] Quote from Participant 2
[421] Quote from Participant 13

these traits are less biological and more a result of society's conditions and ideas of what a man should be, and how a man should act. Therefore, there appears to be a general barrier or Muslim men accessing mental health services as a result of views of masculinity; creating fears of being perceived as weak or emotional.

Similarly to this idea, some participants noted that Muslim men did not have anyone to speak to regarding the issues they were going through and noted a fairly lonely existence with only surface-level friends. While they may have a partner they can speak to, the question was asked or where could they go if they needed to vent about said partner. Participant 13 said,

> '*You might want to vent about your partner, but then that might come across wrong 'cause you're talking bad of your partner as well, so it's a fine balance between is the intention like talking bad of your partner, or are you trying to talk and vent and gain advice? I just feel like there's no formal place for men to go for support.* '[422]

This participant also discussed the quality of male friendships and relationships. He said,

> *'A lot of relationships for men are very surface-level as well, like maybe in contrast to women. They have a smaller group of friends, but [there is] much more deeper connections with women. Whereas men, we usually have a wider group of friends, and they know less about us. So, you know, we do not have to kind of get emotionally involved with other men.* '[423]

Participant 2 also emphasised that he felt he could not talk to anyone about what he was feeling, as he did not want to be a burden to his loved ones. He described that even when it was himself that was experiencing grief, he still had to be strong for his entire family, as that, he felt, was what a man did. He said,

> '*Eventually, I may speak to my wife. But then I'm also very cognisant of the fact that while I do not really want to be increasing her burden, yeah, you know what I mean? So, I probably do not have anyone. Have a few friends. But then it comes on to life experience. [There's] no point me seeking the advice of someone who's had way less life experience.* '[424]

Whilst he felt he wanted to speak with his wife about his challenges, he noted that he did not want to add to her stressors, even if it may have helped him by doing so.

[422] Quote from Participant 13
[423] Quote from Participant 13
[424] Quote from Participant 2

Participant 14 added to this notion, saying,

> '*I think perhaps culture, religion, makes it a bit worse. [Men] generally do not tend to want to come forward and speak to someone, it's not one of those things that men do. We do not tend to talk about our feelings that much. Unless you've got someone who you trust to talk about their feelings.'* [425]

This participant felt that often, Muslim men will not speak about their mental health generally, irrespective of culture or religion, though these factors may make the act of coming forward more difficult. He goes on to add,

> *'There's a really interesting video which is going around on TikTok, which I saw the other day. A question was asked by a woman and people duetted it, but someone compiled the men's responses. The question was "who's one person you can talk to when you're feeling at rock bottom zero?" A lot of the men's answers were, "I would not talk to anyone", "I have no one I can talk to" I think a lot of men probably feel that situation where, if they have good family, or they have a relationship or a marriage that they're in, they probably may open up that person. But if they do not have that, they're not likely to open up to anyone else. They're not going to open up to their friends unless they have a really close friend who would do that. They're more likely to sort of suffer in silence, or not express how they're feeling. Historically, in media, or biologically, we're not people who are comfortable talking about how we feel, to anybody.'*[426]

While Participant 14 felt that men regardless of their backgrounds found it hard to open up especially about their mental health, he thought that culture and religion could make it even more difficult. He emphasised what Participant 2 said, that men feel like they do not have anyone to speak to, and are more likely to "suffer in silence", or "grin and bear it".[427] This notion that many participants felt that they could not speak to anyone about their mental struggles is similar to what I and my colleagues found in our 2019 research report for Muslim Youth Helpline, that over 40.2% of young men surveyed spoke to no one when they last had a mental health issue.[428] This idea is reiterated by a recent study from the mental health charity MIND, which said that almost 20 million adults in the UK never speak about mental health.[429]

[425] Quote from Participant 14
[426] Quote from Participant 14
[427] Quote from Participant 2
[428] Hekmoun et al., "Muslim Youth: What's The Issue?", 7.
[429] MIND, "Almost 20 Million Adults Never Speak about Mental Health – and It's Set to Get Worse Due to the Cost-of-Living Crisis," accessed February 25, 2023, https://www.mind.org.uk/news-campaigns/news/almost-20-million-adults-never-speak-about-mental-health-and-it-s-set-to-get-worse-due-to-the-cost-of-living-crisis/.

Echoing the idea that Participant 2 stated of Muslim men just smiling and getting on with things; the idea to "grin and bear it". [430] Participant 17 discussed these challenges by saying,

> '*For me … to be a man I'd have to know right or wrong. I'd have to have responsibilities. Take care of them responsibilities. And still have a smile on my face even though… I don't want that smile on my face, but we still do that because we're men and we've just got to get through the day, and we say 'Alhamdullilah'. Because I'm fortunate to have clean water, clean food, and I have the pleasure of, and I have the fortune to, buy food, small luxuries. So anytime I feel some type of way about being a man, which sometimes is hard, I look at the positives and weigh out the negatives.'* [431]

He addressed the commonly held idea that was briefly explored earlier in this thesis. The idea that Muslims should be grateful for what they have in comparison to poorer people around the world and therefore should not complain about mental illness. This idea is one I disagree with but is nonetheless prevalent amongst some in Muslim communities. There exists many mental health support services run by Muslims, for Muslims, available in the U.K., which help to address mental health issues. This signifies that the need for these services is there, despite this idea around not complaining.

Aside from various news articles documenting the role of Muslim ideas of masculinity on the effect of Muslim men's mental health, there is not considerable established literature on the subject. More broadly, work has been done on ideas of general masculinity and mental health. I examine these ideas and how they may best relate to Muslim notions explored within my data. I use the concepts of masculinity explored by Connell in their book Masculinities. I also cite texts on Islamic and Muslim masculinities by De Sondy and Ouzgane (ed.).[432] However, these books on Islamic masculinities seem to focus mainly on either South Asian Muslims specifically, as in the case of De Sondy, or Muslim men in Muslim countries, as in the case of Ouzgane. While both provide value in their respective contexts, neither offer conclusions that would fully represent the subjects I interviewed. Both works discuss the links between masculinity and mental health.

[430] Quote from Participant 2
[431] Quote from Participant 17
[432] De Sondy, *The Crisis of Islamic Masculinities*; Lahoucine Ouzgane (ed), *Islamic Masculinities* (London: Bloomsbury, 2006).

The book Islamic Masculinities edited by Ouzgane, discusses in depth the ideas of masculinity in Pakistan. Ahmed, a contributer, discusses views of masculinity in Pakistan and South Asia in the chapter "Gender and Islamic spirituality: a psychological view of 'low' fundamentalism". This chapter focuses on spirituality and mysticism, specifically looking at how the divine may connect to Muslims and how Muslims may seek spirituality through gender. It speaks briefly of sexuality and the concepts of the masculine and feminine. There is discussion in this chapter about the masculine and feminine being opposite but complementary to each other. Ahmed explores the concepts of *Jalal* and *Jamal*, two of the 99 Names of Allah, where he argues the former is seen as masculine, and the latter as feminine.[433] In works which examine masculinities in particular countries, the countries themselves are often seen as monoliths within themselves, ignoring the various languages and cultural identities that make them up. We cannot look at Muslim men as a homogeneity, nor can we look at all Muslim men from specific cultures or ethnicities as homogenous; but we are able to make certain generalisations from similar answers given by Muslim men of different backgrounds. It is also important to not judge views of masculinity as staunchly right or wrong, as to do so may encourage prejudiced view of certain ideas, when they may just be cultural differences. However, what we are able to do is to acknowledge any negative or positive repercussions that these views may affect.

At the end of the interview, when I asked Participant 4 if he had anything else to add, he discussed that he was not taught the softer side of Islam.

> '*I've been brought up that and not been taught about the kind of softer side of Islam. Everything is very much, kind of "if you do not do this, you're going to go to hell". And that softer Sufi side is not really taught. And I think that as time is changing and as the second generation, I suppose, is having better standards of living, better education, the desire to learn about Islam, whereas they've just been taught from their parents. I think that softer side of Islam is coming out and I would hope that that would help kind of balance it out and let men show their - not their weaknesses- but their softer side.* '[434]

Though the participant described soft here as "Sufi", this could also be interpreted as the concept of *Jamal* as explored by Ahmed. It is interesting to note here that this participant equated Sufism to softness, and attitudes to and the impact of Sufism as it relates to Muslim masculinity, could be a point for further study. In this instance, Participant 4 noted that the

[433] Durre S. Ahmed, "Gender and Islamic Spirituality: A Psychological View of 'Low' Fundamentalism," in *Islamic Masculinities* (London: Bloomsbury, 2006), 20.
[434] Quote from Participant 4

softer side of Islam would help men in their lives, but he was quick to differentiate between weakness and softness. This differentiation and emphasis on the *Jamal* may be a useful reiteration for communities to promote the understanding of softness and how this is an Islamic concept. In turn, this may encourage more men to seek help about their mental health and to open up to those around them. Participant 4 also discussed that second-generation individuals, have a desire to learn about Islam in a way that is not from their parents, suggesting that parents would take a more cultural approach to teaching about Islam, compared to self-studying which may encompass other aspects of Islam.

To summarise this, these notions of masculinity affect men's mental health in different ways. Within the Muslim community men are encouraged to be tough (*jalal)* and not talk about their emotions, promoting feminism as *jamal* and discouraging it, the importance of sex-roles, and a skewed view of what it may mean to be a man. These notions may all affect men's mental health in different ways and will be explored further in the following sections.

Ali also acknowledged the lack of concentration on masculinities within the study of gender and Islam. Although Ali argues that gender in Islamic Studies has focused on women, this again is Islamic Studies in the sense of what the religion may tell us about gender and gender roles, not necessarily what is practised currently. She gives examples of masculinity from the life of the Prophet and compares Christian and Muslim examples of masculinity from Muhammad and Jesus.[435] While it may present as the Muslim ideal, it does not talk about the actual practices of Muslim men in the present day.

Britton studied the relationship between Muslim men in the UK, racialised masculinities, and their personal lives.[436] She argues that the personal lives of Muslim men and how this may relate to masculinity, has been under-researched. Therefore, this is an aspect which could affect masculinities.[437] Britton notes that by looking at the personal lives of Muslim men, 'provides a valuable window on men's live'" and through this we can gain a better understanding of male roles and masculinities.[438] This thesis does exactly that. It has examined the personal spheres of Muslim men, namely their relationship with mental health,

[435] Kecia Ali, "Muslim Masculinities: Men Have Gender Too by Kecia Ali," August 21, 2012, https://feminismandreligion.com/2012/08/21/muslim-masculinities-men-have-gender-too-by-kecia-ali/.
[436] Joanne Britton, "Muslim Men, Racialised Masculinities and Personal Life," *Sociology* 53, no. 1 (February 1, 2019): 36–51, https://doi.org/10.1177/0038038517749780. 36.
[437] Ibid.
[438] Ibid.

and uses this to analyse their views of masculinity. Britton uses accounts of the grooming gang crisis to examine masculinities. However, due to the media, these accounts were referencing 'perpetrators as Asian or Pakistani'. Therefore, while the focus on these cultures may have some basis towards my work, they cannot be considered exact, as Muslims are not just Asian or Pakistani.[439]

Britton used an innovative methodology to study these men, as she collaborated with local Muslim women to form the design of this study.[440] She ensured that none of the women were related to the men she studied, but nonetheless it remains an inventive methodological point to use multiple local women to help design a study which focused on masculinities and men. This methodology seems innovative as it was the first study I found which used this methodological framework. It allowed for there to be discussions on how these Muslim women may perceive male roles and masculinities. Furthermore, it raises the question of why Britton eschewed using men to design the study.

Staiger et al wrote about how ideas of masculinities may prevent help-seeking in depressed men.[441] They noted the ubiquity of studies which reviewed the 'adverse effects of male role expectations and social pressures to perform as well as family providers'.[442] Though this was a German-based study, we can acknowledge similarities between what they have noted and this thesis's findings within the British Muslim community, specifically in regard to role expectations. They also noted that depression (as men suffering with depression were the focus of their study), was 'perceived as a threat to men's roles as a family provider'.[443] Expanding on this is the idea stemming from the interviews presented in this thesis that poor mental health or mental illnesses more generally can be a risk to these entrenched male roles, and therefore may affect how these men are perceived by others.

[439] Ibid, 37.
[440] Ibid, 40
[441] Tobias Staiger et al., "Masculinity and Help-Seeking Among Men With Depression: A Qualitative Study," *Frontiers in Psychiatry* 11 (2020), https://www.frontiersin.org/articles/10.3389/fpsyt.2020.599039. 3.
[442] Ibid.
[443] Ibid.

What does it Mean to be a Man?

The question of defining the roles and meanings of a man was something which I put to my participants. Each detailed a difference between the role of a man in their culture, and the role of a man Islam by their understandings. These differences were sometimes at odds with each other, and participants often noted a difficulty with merging the two in a way that ensured they were loyal to their faith. Generally, the majority of men described their roles as in direct compliment or comparison to the feminine, implicitly ascribing to the aforementioned sex-role theory by Connell. The idea of what it means to be a man, as impacted by culture and ethnicity, was covered in the previous chapter of this thesis.

Participant 3 felt that Muslim men had a larger responsibility to bear than Muslim women, and this was inherent to their roles. He stated,

> '*So, you know women in terms of being a witness, or you know, like the inheritance shares and something for some reason, men tend to have a responsibility that is greater than that is placed in a woman, so that's my basic understanding.* '[444]

Participant 3 also discussed the responsibilities of a Muslim man in terms of decision-making and other responsibilities at home in relation to the family, in addition to legal responsibilities such as being a witness, or inheritance, as mentioned in the above quote.

Participant 4, who is from the same cultural background as Participant 3, defining themselves as British Pakistani, discussed the role of a Muslim man being different between culture and Islamically, emphasising that he feels that the cultural role of a man as a breadwinner does not seem to be changing with generations. He noted that the role of a man in Islam could present differently depending on the stories and sources by which you obtain your information.

> '*I would say the role of the man is still, very much seen, as the breadwinner. And that definitely does not seem to be changing as a cultural identity, I would say; but maybe kind of locally, within families that is changing. That seems to have changed, it's certainly in my family and I've seen that in other people's families. But generally, culturally, I do not think that that has changed. Islamically, I guess it depends on how you want to view Hadith and how you want to understand stories. In my opinion, I would say that a man's role generally is to be the person who's working, and it is maybe the woman's role to look after and nurture the children. It's my interpretation,*

[444] Quote from Participant 3

> *but I would not say I'm particularly learned in Islam and I'm slowly learning these things, and maybe I've not looked into it and I'm just going on what I've been taught growing up.'*[445]

Interestingly, Participant 4 does not see overwhelming cultural change but sees it from family to family. This may be for two reasons. Firstly, it may be a cultural taboo for anyone other than a man to be seen as a breadwinner, so others are reluctant to share this information. This mirrors what Participant 8 said about the taboos of women being a breadwinner in Arabic culture, saying, '*if it is in Arabic culture, a woman leading the family, in terms of financially, would be embarrassing for them, to be honest*.'[446] Secondly, it could be that this change is happening slowly, so there is not enough overall change to be definitive.

Though Participants 3 and 4 are of the same cultural background, other Muslim men I surveyed of different backgrounds felt the same way. Participant 8, who is of Arab background, noted that in his Arab culture a man,

> '*Should be the person who is in control of his house with his wife and his children. In [this culture] a man would be blamed for any immoral acts being conducted by his wife or one of his children, thinking that a man should be advising and controlling over [them].'* [447]

However, this participant also acknowledged that this was different to what he interprets the Islamic idea of a man to be, saying,

> '*[A] Muslim man has a responsibility, but he does not have such kind of control. He is responsible for providing advice and help for his wife and his children. Islam makes it clear that each individual person is responsible for his or her acts. Even if someone is committing something which is not legal or is not Islamic. The man's role is not to overcome this or to control this by force, but through advice and through finding the appropriate help, finding someone who is a counsellor, [or] family member to advise. His way is like a doctor, not a judge.'* [448]

In this instance, this participant categorised the main differences between cultural responsibility and Islamic responsibility to the concept of differing responsibilities; that Islamically, individuals are only responsible for their own actions, but in his Arab culture, this responsibility of a man spans over others, especially his immediate family. He stressed

[445] Quote from Participant 4
[446] Quote from Participant 8
[447] Quote from Participant 8
[448] Quote from Participant 8

that though it is a man's responsibility to advise and assist, it is not his responsibility to force or control a decision, especially those being made by women.

As part of the final question of the interview, asking the participant if they had anything else to add on any of the subjects discussed throughout the interview, Participant 3 stated:

> '*When addressing mental health among Muslim men, I think that … the two major issues are, you know what you said when I did… trying to identify gender roles and define the identity of a man. And the second is the … cultural where it's separating the cultural identity from the Islamic identity... I mean culture, it's- it may be affected by religion, but it never is religion. Religion does not really have a culture as such. Then that's probably been the one thing which has stuck out to me thinking about it, which is I haven't really thought about it before. It is actually the more we try and identify ourselves as Muslims, probably the more likely we are to escape these norms and these sorts of dogmas which forced us into a corner. Yeah, … I think it's been really interesting.'*[449]

It is interesting that this participant said that he had not thought about mental health among Muslim men before, despite finding the interview and research "really interesting". This suggests that conversations directly around mental health do not take place amongst this man's immediate friendship and relationship groups. He noted the challenges both of identifying what it means to be a man, and to then how to separate the ideas of religion from the ideas of culture. He spoke about how every individual living in the UK is of a different or multiple ethnic backgrounds, and is therefore a mix of different cultures; so, it can be difficult to identify with one over the other, or to separate them.

> '*I suppose we're sort of like a juxtaposition of multiple cultures. In the culture which I most identify with I would not be able to identify what it means to be a man, about what it means to be a human being. OK, in the way that I live my life when I see things, but I understand the impact of the different influences on me. So, from the Pakistani heritage. Being a man generally denotes being a head of a household, making all the decisions having power over your household rather than just simply responsibility… I tend to overlook the traditional, the identification of the male role that comes from the Pakistani culture because you know, being blessed with having an influence of multiple cultures, and you know we also at the same time reserve the right to reject certain things as well as absorb the things which we feel are beneficial so in in terms of the cultural implications I'm fairly confident that I can reject a lot of them based off are my experiences over here.'*[450]

[449] Quote from Participant 3
[450] Quote from Participant 3

He stated that this inability to separate the cultures have implications when trying to determine the roles of a man. Although they may be clear within Pakistani culture as he mentioned, when a person is intertwined with other cultures, it can be difficult to define. Interestingly, he used the word 'power' to describe the role of a man, which implies a kind of explicit control over family members.

Participant 6 who is of Arab heritage defined his opinion of the role of a Muslim man Islamically to be,

> *'So basically, like as a Muslim man… Basically, there's a level of segregation that you're expected to have … that's different compared to [Arab] culture, ... But you know it depends on how practicing you are, and it's not completely segregated. ... If you have, like co-workers, you're expected to have a professional relationship. But in terms of the family relationship, you're meant to only be with your wife and the mahrams.'*[451]

This participant felt that an important part of what it meant to be a Muslim man is to segregate yourself from the opposite gender, only being around those to whom one is considered a mahram.[452] He was the only participant to discuss this issue; and upon reflecting, this could have prompted further questioning from myself as the interviewer.

Participant 20 also related his view of the role of a Muslim man to their relationship with women, both in his culture and within Islam, saying,

> *'From the outside … there's one or two things which are the same which they manage to protect women. But if you look at the culture, culture, day to day, life of women and what they expect it to be typically is different depending on how religious they are.'*[453]

These participants based their view of masculinity based on their relation to femininity. This links to what De Sondy stated in that Islamic masculinities tend to be studied only for their relation to femininity.[454] Perhaps this is why; that the men themselves think about masculinity in this way. Participant 16 based his view on what a Muslim man is on the relationship between the Prophet Muhammad and his wife. He said,

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[451] Quote from Participant 6
[452] A mahram is someone in an individual's family who marrying would be considered forbidden. For a man, this would be their mother, grandmother, sister, or aunt.
[453] Quote from Participant 20
[454] De Sondy, *The Crisis of Islamic Masculinities*. 4.

> *'The gender roles… that I see in Islam, I based very much on the relationship between the Prophet (peace be upon him) and his wife and his daughter's daughter. Particularly at Aisha, … that's a very clear indication of the positionality of women. You know that the first Muslim was a woman, and so this idea of equal and yet different, something that I'm very comfortable with and is probably one of my bigger attractions to my faith.'*[455]

Participant 16 explicitly stated the position of women in Islam and noted their complimentary nature to men and vice versa. When asked which specific responsibilities that a Muslim man may have which differ to that of a Muslim woman, the participant reiterated that he felt that Muslim men and women were different yet equal. He said that some roles which may be traditionally seen as feminine such as the role of parenting, is something he felt was down to both genders, and was a role which he had undertaken. He also noted that he saw misogynistic views coming from many Muslim men, not as a direct result of Islam itself, but of cultural interpretations of the religion. He said,

> *'I'm aware of a lot of the kind of misogyny that emanates from a lot of Muslim men. And I really battle with that. But I do not really see it as an issue with the religion as much as an issue with the men themselves. Well, I think for them it is coming from their religion, but I think it's often a cultural thing. I think that dumb. I often have spoken to my wife about the fact that there are some problematic attitudes towards men and women that come out of specifically the Arab world that existed that existed pre–Islam. That Islam has had a real challenge to subjugate these attitudes, which aren't Islamic but have but have kind of followed through.'*[456]

What is the Effect of the Responsibilities of a Muslim Man on their Mental Health?

The above question was something I wanted to explore with each participant. From this, communities and societies can best understand some of the causes of poor mental health in Muslim men and begin to make structural and institutional changes to improve circumstances and outcomes. In turn, this may encourage more Muslim men experiencing mental health difficulties to seek help for their issues.

[455] Quote from Participant 16
[456] Quote from Participant 16

To determine this, it was apparent to review what the Muslim men interviewed believed caused mental ill health. Overall, most of those interviewed felt that there was often a medical cause for mental ill health, or as a result of a period of intense stress or difficulties. This may be increasingly common amongst individuals who are refugees or asylum seekers, who may have specific mental health issues related to this. Within this study, no participants disclosed whether they were refugees or asylum seekers. Some identified as first-generation immigrants, but not as refugees or asylum seekers. One answer especially emerged, where Participant 12, a medical professional, stated that he often wondered if poor mental health was due to a fault of his own. He said,

> '*But also, there's also part of me that wonders, am I being punished for something? Yeah, you know, is my mental health a result of some actions that I've done, or is it something that I'm doing?'*[457]

This was especially interesting to note, as it suggests a blame onto oneself despite also acknowledging that,

> '*Any amount of mental health is nothing different compared to being pricked with a thorn in your finger. You know, it's still a suffering. It's still a disease.'*[458]

Despite Participant 12 being a medical professional, he felt conflicted when it came to the causes of his own mental health, thinking that it is a result of an action that he has done, rather than as a result of genetic, biological, or social factors.

Participant 15 noted the idea that had come up multiple times, that it is a Muslim man's responsibility to lead his community, saying,

> '*[Muslim men have] some religiously ordained responsibility to be shepherds to our families and within our communities as well. I do believe that Muslim men, we do have to be facilitators. We have to be facilitators within our societies and for our families, where we need to make sure that we are educated well, so we can help lead our communities and our families. We need to be principled. We need to frame our worldview predominantly through the Sharia first, and then our understandings through the Seerah. I think a lot of Muslim men have unfortunately become very jaded by not understanding Islam properly, or like making it like a gender war or something like that. And it's not healthy. It's not right because then we go the opposite to what we're meant to be which is those who are strong in society and upright and helping move the cogs in a healthy way.'*[459]

[457] Quote from Participant 12
[458] Quote from Participant 12
[459] The Seerah is the life of the Prophet Muhammad; Quote from Participant 15.

This idea of an increased responsibility put upon Muslim men is something that may turn into a pressure on their mental health. The use of the repeated terms "have to" by this participant really emphasised that the attributes of the role of a man was something non-negotiable and is a duty on men. Participant 15 also spoke about the impact that the responsibilities of what he felt was the role of a Muslim man, as a leader, on mental health.

> *"I've only began to feel this since I have come to my mid 20's I would think. I would say prior to around 25, 24, I didn't really feel any sort of external pressures or expectations as a Muslim man to be completely honest. There was two pressure I began to feel, one was from myself internally and there were others externally. Internally, I began to feel 'oh my God I'm in my mid 20s, I've not ever properly studied Islam.' One day I'm going to have my own family inshallah, one day I'm going to be someone in my community, because I've always been active in the community."*[460]

Participant 16 said that he himself did not feel any particular pressure which affected his mental health, as a result of being a convert and not being Muslim his whole life. In this instance, the participant is referring to external pressures that come from being within a predominantly Muslim culture, such as cultural expectations of what a man should be. However, he did state that he had found this amongst other individuals that he knew, saying,

> '*I've lived in very different societies where if I allowed society to pressure me into behaving in a certain way, I would not be the person that I want to be. But yes, absolutely with those around me, I can see it as often a real issue. You'll get again with my family in the Middle East. For example, you know you get a lot of young men, and they're quite confused because they're getting these mixed messages about who they should be and what they should be. And you can see that this is a real kind of challenge for them.* '[461]

This perhaps suggests that the younger generation is affected more by these pressures than the older generations, as this participant is in his 50s. He added that it is difficult for individuals from Muslim cultural backgrounds to differentiate between Islam and culture. This is a notion which has come up many times within this research. He remarks,

> '*I mean, a lot of it is cultural, you know? Yeah, it's difficult to kind of separate what is Islamic. But it's Islamic to them, yeah, and so therefore it is probably pertinent. But this thing about, you know, marriage: and who to marry and when to marry. I find there seems to be a bit of conflict for young Muslim men who want to have a*

[460] Quote from Participant 15
[461] Quote from Participant 16

certain relationship with women, but really do not know how to. Their culture does not allow them to understand.'[462]

The Use of Islam as a Coping Mechanism

As mentioned in the previous sections of this thesis, Muslims and those belonging to religions often use their religion as a means of comfort in difficult times. Dein and Bhui's study which was referenced in the Literature Review found that there is a lack of research on how ethnic minorities may use religion to cope with stress.[463] Though stress and mental ill health are not interchangeable, stress can be a cause or a symptom of mental ill health or a period of low mood. Participant 21 discussed using religion to cope with stressful or negative experiences, saying,

'*Often when I am feeling stressed or negative, I turn to it as a way of kind of coming out of that place. Or trying to tell myself, if I mess up or do something wrong, that Allah is forgiving and accepting. And you've just got to look for that, and I think it definitely helps me with direction, when I'm lost, not really knowing what the next step is, I use it as a kind of way to ground myself.'*[464]

Participant 10 also said that when he experienced periods of mental ill health, he would '*definitely come back into my faith and pray'*[465]. This means that Participant 10 felt that prayer would help in his mental ill health recovery. However, overall participants did not necessarily favour seeking religious help over psychological or medical support. In fact, many participants spoke about not wanting to seek help at all.

Participant 11 made an interesting point, and said he used religion as a coping mechanism when either things were going especially well or especially badly, but not when things were at a middle ground or status quo. He said,

'*I do not know like how much me praying, and being kind of, like, regular in my prayers, or like even being kind of like more conscious of my religious obligations is like, I do not know, it's like a coping mechanism. If anything, I think it's like a good litmus test for how I'm doing. Like, if I'm praying regularly like things are either going fine or going badly… and that's what I'm focusing on.'*[466]

[462] Quote from Participant 16
[463] Dein and Bhui, "At the Crossroads of Anthropology and Epidemiology." 783.
[464] Quote from Participant 21
[465] Quote from Participant 10
[466] Quote from Participant 11

It is interesting to note that this participant felt that he most needed religion in times of extreme highs or lows, both to cope with positivity and negativity in his life. However, this participant did not describe using religion as an ongoing protective factor for his mental health.

Participant 2 used religion in a manner of negative coping, saying,

> '*I understand the importance of these things, although I did probably just pray away... I see it as personal sacrifices for the greater good at that moment in time.'*[467]

In this instance, he described choosing to pray instead of seeking help through other means, as if he had sought out other mechanisms that would be at a detriment to others. He felt that through making this sacrifice of not seeking help for himself, it was of greater good for those around him. Though we are unable to determine whether this is a regular occurrence, we can conclude that in this instance, religion was used in a way to negatively cope with the situation.

Participant 4 used prayer in a different, more positive, way, as something which made him feel better and as a result did not need to seek further help. He said,

> '*I cannot give people this advice all my life and then sit here and whinge about the issues that I'm going through. I would make an effort to go to the masjid and pray with the congregation, because I felt much better for it. And, in comparison to other people's issues, they weren't big issues, but they were issues that affected me and looking back at it, you know I'm glad that's the way I did deal with it… I didn't feel like I needed it [professional help for mental health issues].'*[468]

This shows an example of how a Muslim man may use religion to cope with issues. It shows a positive way of coping, as when this participant looked back on his situation, he still felt positive about the way he dealt with it, and the ritual of prayer was able to give him what he needed at the time. It is an important distinction for practitioners and professionals to acknowledge that prayer and other forms of worship may help Muslims who are struggling

[467] Quote from Participant 2
[468] Quote from Participant 4

with mental health; but for others, particularly some within the Muslim community who do not encourage treatment for mental ill health, it can be a danger.[469]

Changing Attitudes towards Mental Health and Mental Illness

I asked participants whether they thought that attitudes towards either mental health in the Muslim community, or what it means to be a Muslim man, are changing. I surveyed men aged from their early 20s to their mid50s, and there was a general sense among participants that things are changing within younger generations. Participant 2, who was in his mid-30s, noticed a slight change within his age group but an increased change with those of a younger age, saying,

> '*In the Muslim community, I think they are [things are changing]. Amongst Muslim men my age, so like from about like 35/36 upwards, I'm not too sure. If someone really put me on the spot and said you have to decide, I'd probably say no… There probably is a change, but I think at the moment [it's] borderline negligible or small. Those younger than that maybe, if the change is being driven, is probably being driven more by the females. And that should and may have a knock-on effect on the males; and the males who are in contact with those females or the families that they are in, they may drive that change. But if I just think about the conversations I have with my friends, or you know the other men in my family, thee seems to be this same male bravado.'*[470]

He described that change was being driven by women, rather than men, suggesting a dormant reluctancy or hesitancy for men to discuss their mental health. In this case, Participant 2 was discussing the changes in attitudes towards discussing mental health within the Muslim community, and whether there was still associated stigma or taboo around these discussions.

Participant 4, who is a second-generation immigrant to the UK, said that things are changing amongst the third and fourth generations of Muslims in the UK.

> '*I do think so, and maybe that's not to do with Islam personally, but it may be that again, we are only second generation and there's some third generation, but maybe those issues haven't been kind of teased out. They're not going to be teased out by the third generation because they're still quite young. They are still being kind of played with and teased out by the second generation… I suppose if I look at my father's generation, they didn't have the time to be dealing with mental health issues. You*

[469] Haleh Banani, "Shattering The Stigma of Mental Illness," *MuslimMatters.Org* (blog), March 15, 2017, https://muslimmatters.org/2017/03/15/shattering-the-stigma-of-mental-health/.
[470] Quote from Participant 2

know, if you had mental health issues, you needed to kind of bottle them up and pay the bills and bring your kids up. The second generation may be kind of less focused on having to work seven days a week, and you know they've got more understanding of these issues. And maybe the third generation it will change, but I think those issues are still there. They are getting better, they are being teased out, but I would not say that they did anywhere near where they should be and [there is] that expectation to bottle things up.'[471]

He summarised the main issues with why the first generation (here meaning the older generation) did not seek help for mental health issues. The reason for this is because they had to focus on work and providing for their family at a time when this generation migrating to the UK meant they had little money, and usually only the man in the family was working; the gender roles were more entrenched. On a positive note, this participant believes that "things are getting better", despite the expectation amongst men to still leave their feelings unexpressed. For further research, a longitudinal study could be completed to examine views and experiences over a period of time, in addition to a generational study exploring the same ideas.

Participant 12 noted that he felt the causes of mental ill health were situational and biological or genetic. He also made an interesting argument that the causes of mental ill health could be cultural; meaning that a certain element from a person's culture may cause them undue stress which, in turn, could negatively impact one's mental health.

'*Number one: it's situational. Yeah, absolutely, number two: it's biological. There are certain things we should run in families that may have a genetic component to them…. Certainly, things like depression, schizophrenia, things like that might have a genetic component to them, they can run in families. So situational, biological, genetic, but also cultural. So, what you consider to be stress might just be something that other people, because [of] their culture, they considered part of their day-to-day job. It's OK, it's not stressful, that's just what you're supposed to do, so it's cultural expectations.'*[472]

This links to what Participant 4 stated about older generations perhaps not having time to deal with mental health issues. Certain features of one generation, or one culture may mean that the individual from that generation may not have the same reaction as those from another generation. For example, if mental ill health is more understood in the present generation due to increased education on the topic, then older generations may be less likely to access the education.

[471] Quote from Participant 4
[472] Quote from Participant 12

What is the Impact of Living in Wales?

One of the reasons I chose to focus on Welsh Muslim men as opposed to Muslim men in the UK more generally is because of the unique ethnic makeup of the county, particularly the south Wales region. As mentioned in the Literature Review, unique to the Cardiff area of south Wales are the historic Somali and Yemeni communities, as well as more recent arrivals of Muslims from other parts of the Islamic world.[473] According to the 2021 census, the second-highest level category of ethnicity was "Asian, Asian Welsh, or Asian British" at 2.9% of the Welsh population, compared to 2.3% in the 2011 census.[474] 1.6% of the Welsh population defined themselves as "Mixed", up from 1% in the 2011 census, and 0.9% of the population identified as "Black, Black Welsh, Black British, Caribbean or African" compared to 0.5% in 2011.[475] The ethnic makeup and history of the Muslim communities of Wales means that many Muslim cultures and views have been, and still are, intertwined. Though by virtue of someone being of an ethnic minority someone is not automatically Muslim, and vice versa, the majority of the Muslim population are part of the BAME population. Many participants spoke about the impact living and being brought up in Wales had on their views and outlooks.

Participant 2 noticed a difference between the attitudes of Muslims living in Wales, and those in cities in England, from his experience, saying,

> '*My wife is from [CITY IN ENGLAND]. So we visit [CITY IN ENGLAND] a lot. Very familiar with it, family there. And yes, people of the same age. So for example, like my nephews, nieces, younger cousins in the you know, early 20s, late teens, the ones in [CITY IN ENGLAND] who are in predominantly Muslim not even most predominantly Pakistani areas, probably do have those ideas and views a little bit more entrenched than my family here in South Wales. So yeah, I would probably say that's probably correct. Yeah, because we are more diverse, or more of a minority really. I mean, there's less of us here,... so yeah, but I think that does play a factor'*.[476]

[473] Genna, "Syrian Families Find a Warm Welcome in West Wales | UK for UNHCR," United Kingdom for UNHCR, March 17, 2021, https://www.unrefugees.org.uk/learn-more/news/refugee-stories/syrian-families-find-a-warm-welcome-in-west-wales/.
[474] "Ethnic Group, National Identity, Language and Religion in Wales (Census 2021)."
[475] "Ethnic Group, National Identity, Language and Religion in Wales (Census 2021)."
[476] Quote from Participant 2

Here, he was replying to whether ideas that he had mentioned before about men in his Pakistani culture viewing masculinity as being *"shouty, be aggressive, dominant"*, whether this view was prevalent amongst UK Pakistanis, particularly amongst Welsh Pakistanis. He said that there is a difference between those areas or cities which are more heavily Pakistani culture, as opposed to south Wales which has more cultures intertwined. Additionally, there exists differences within south Wales where some areas have a higher Muslim population than others.

Participant 7 agreed with Participant 2's point, describing the impact of living in a multicultural area of south Wales,

> '*Yeah, I mean being like from [area in Cardiff] is like really multicultural, so I think that plays a big part in it. I think equally if you look more to the West in general, there is like more of an acceptance of how men, aren't expected to be what used to be 'make a man a man'. It's just becoming less and less. They've got toxic masculinity linked with it now. And also, because I did attend [a Christian school] and that was pretty much all white, I was like the only Muslim in my year in year 13, and so I kind of like adopted that as well. I wasn't just like take [another school], for example, where it was just all Pakistanis... It was a case of me just being around Caucasians, and so I think that had a quite big impact as well.'*[477]

This participant grew up in a multicultural area of Cardiff but attended a predominately white school. He believes that both of these factors have an impact on the way he views what it means to be a man, and his views on life more generally, compared to if he had experienced a school which was made up predominantly of the same ethnicity that he is.

Participant 8 also noted that living in Wales has had an impact on his views, he stated,

> '*You should also respect the communities and the societies and the openness in which we live in. This is one of the things I'm noticing. Another thing I saw, some families where women are taking the leading position. If this word is correct to be used in the family because the woman is able to do a business and to earn money. The man's role becomes to support, just to support her business. And she is running the business, and the man's position or role is just to help her. This is developing some kind of leading position to the woman, and this could have some concern for some men to some extent. And some others would see this like ordinary, and this is consistent with the culture they are living in. The culture here could affect them to accept that, or to alleviate the concerns and the worries. If it is in Arabic culture, a woman leading the family, in terms of financially, would be embarrassing for them, to be honest.'*[478]

[477] Quote from Participant 7
[478] Quote from Participant 8

This participant noted how living in Wales has affected his views on society, especially in regard to a woman earning and being the provider of a family. He did not grow up in Wales but grew up abroad, and explained the differences between what he sees happening in Wales and what may occur in Arab countries [in which he grew up] should a woman be seen to be leading or supporting her family financially. This participant felt this was a cultural difference between Wales and Arab countries, rather than something forbidden by Islam.

Participant 14 discussed the differences between a city such as London, and Wales. He felt that communities in Wales were more integrated due to the mix of cultures that are spread out across different areas.

> '*I think London is probably a lot more insular in the communities that they have there. By the communities that are so inward rather than going outwards; whereas, well, I think Wales the community is a bit better integrated in terms of the whole the picture with each other as a bit more as well. So, I think that's a positive thing and even sort of with …the non-Muslim cultures and things they're a bit more integrated than perhaps London is.'*[479]

Interestingly, he made a comparison with London and suggested that the insular communities distinguished along ethnic or cultural grounds, were less integrated than those in Wales, who he did not describe as insular.

Participant 15 discussed the impact of living in Wales, saying,

> *'Where I am in South Wales, the two main ethnicities you will see are Bangladeshi and Pakistani. There is a big Yemeni community here and a Somali community, but they do tend to keep themselves to themselves I've noticed more often than not. And the majority masajid here in South Wales, they are predominantly either Bangladeshi or Pakistani masjid. And I think there's one small Yemeni and one small Turkish masjid, and that's it, really. I would say that for the … longest part, especially from the late 90s to the early to mid 2000s, you could say there was only one way of kind of knowing or even observing Islam, which was mostly through Bangladeshi or Pakistani ethno-communities. What I have noticed now is there is actually a bit more diversity, when I go to the masjid for jummah now, 10 years ago when I went to my masjid, … I would only see Bangladeshi men. …. Now I see a lot of African brothers, Middle Eastern, you know there's a lot more mix in there now.'*[480]

He noted that in the last couple of decades, the different Muslim ethnic communities in south Wales had become more intertwined. He sees different races in mosques that have been more

[479] Quote from Participant 14
[480] Quote from Participant 15

traditionally one ethnicity. As a result of this intertwining, there has been an increasing diversity and acceptance to the way one can practise Islam. In the 1990s, this participant observed that the main way to practise Islam was that which followed the Pakistani or Bangladeshi customs or schools of thought.

From this data, we can surmise that living in Wales has an effect on the views of those Muslim men interviewed. Though they did not specifically refer to effects on mental health, they believed it had an impact on their views surrounding cultural identity. A comparative study with England could be pertinent to understand whether these contrasts exist.

Suicide, Death by Suicide, and Suicidal Ideation

Due to the statistics in Wales that state that suicide rates in men are almost three times as a high as those in women, I wanted to determine Muslim male experiences of suicide through asking if they had known anyone who died by suicide.[481] I did not specifically ask participants if they had experienced suicidal ideations themselves, since the study itself does not deal with suicide in great depth. Though, I believe it important for future study to have included a question about suicide within these interviews. I asked participants: whether they had known anyone who had died by suicide; whether there had been open conversations about the reasons behind the person's death; or whether other reasons were given. This was specifically in relation to Muslims who they may know who had died by suicide. From the information given by participants, there is scope for further research of suicide and its effects within the Welsh Muslim community or the wider British Muslim community.

Participant 2 described the suicide of someone he knew, though was not related to, saying,

> *'He was from the X area of the city. But this village I'm from in Pakistan, we're quite heavily represented in [South Wales city], very well-known member of the community here. And initially what happens is the conversation begins on, can you do someone's janazah or not?*[482] *Can you pray the funeral prayer or not because they committed suicide?'*[483]

[481] "Latest Suicide Data," Samaritans, accessed October 6, 2022, https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/.
[482] Janazah is the Muslim funeral prayer.
[483] Quote from Participant 2

The participant detailed the lack of knowledge within his Muslim community around Islam and suicide; saying that questions were raised regarding the validity of participating in the funeral prayer of someone who had died by suicide. The participant went on to describe that the notion that the reason for death was suicide was '*hidden from what I remember'.* He went on to describe where the deceased man was from, and the questions which emerged following his death.

> *'Then the conversation sort of moves onto Um? Will he go? Will he be allowed out of hell? Heaven at all or not? And then around about the same time, there were murmurs of "how did they die?" Some people say commit suicide, to the others are saying no, we never. But to be honest with you, if there is suggestion of someone committing suicide 99% of the time, that is what it is. Yeah, then the conversation sort of goes on to "Well, why did he?" And then that is sort of, you know, discussed. I do not remember at any point hearing anything about mental health. But then I have to think back because, for mental health to be discussed, they do not have to mention the words "mental health." Yeah, you see I mean. In terms of, "did anyone mention that? Oh, he could have turned. He should have turned to so-and-so, he could have some." I never heard that mentioned, but then I wasn't as close to that family."*[484]

This participant made an interesting point when speaking about discussions after the period of suicide. He noted, '*For mental health to be discussed they do not have to mention the words mental health'.* This is an idea which could be important for further exploration; perhaps a study that could be conducted in native languages, about the ways in which mental health is spoken about and the vocabulary used around this topic. This also may infer that there should be more of a holistic approach to discussions around mental health; looking at general wellbeing and other determinants that may contribute to positive mental health. One such possibility would be introducing a physical activity with a talking component afterwards, which could encourage good mental health without directly saying the words "mental health". This could also reduce any fears someone may have about discussing their mental health since it would be done implicitly rather than explicitly.

Scope for Further Research

[484] Quote from Participant 2

Based on this work, there is considerable scope for further research. Some of those interviewed were fathers and spoke about "the next generation" of men, i.e., their sons and how ideas around masculinity and mental health were evolving and changing. It would therefore be interesting to examine not only the differences in raising Muslim boys from one generation to the next, but also the impact on mental health and views on masculinity that growing up without a father or in a single mother household may cause.

Due to my location in Cardiff, and the boundaries of the KESS scholarship of which I am a grateful recipient, my work focused on Muslim men specifically in South Wales. As previously mentioned, the South Wales Muslim community is relatively small, requiring extra measures to keep participant information confidential. However, these same measures also limit what can be discussed in this present research. To combat this in further research, a larger sample size is encouraged; not only to preserve anonymity, but also to be able to compare other results to my own. Additionally, it would be interesting to conduct similar research in other regions – areas which consist more predominantly of individuals from one ethnic background. Comparison studies could be conducted with cities or areas with a higher concentration of Muslims to determine whether that factor has an impact. Similarly, it would be useful to examine the views and experiences of mixed-race or mixed-ethnicity Muslims. This would be particularly pertinent if the parents followed different schools of religious thought or had different views on Islam, to see which views impacted the individual the most.

A few of the participants in this study were keyworkers in various roles. Due to the impact of the COVID-19 pandemic on not only the mental health of the general public, but especially on keyworkers, it would be interesting to conduct a study on Muslim keyworkers' mental health. This could include information specifically related to their "Muslim-ness", such as the difficulties of Ramadan and Eid, and having to work during a time when the virus discriminated increasingly against ethnic minority communities.

Another route for further research based on this study could be to interview Muslim men from the LGBTQ+ community to evaluate their perceptions of masculinity and experiences of mental ill health. While not something that many participants mentioned, Participant 12 highlighted it as something he saw prevalent in the Muslim community: the link between sexuality and mental health issues. He said,

> '*Sexuality is a big thing. There's a big percentage of Muslim population, a big percentage, you know, bigger than people would care to admit, that are probably gay, bisexual, or whatever. And then they have mental health problems. And that ties in … But all of this is not to be swept under the rug.'*[485]

He also suggested that Muslims may hide details of their sexuality, either those who identify as part of the LGBTQ+ community, or those in the community who are aware. This reiterates notions of stigma that may exist within the Muslim community around sexuality.

Education

Participants were asked their education level as part of the pre-interview questionnaire. This was to establish whether there was a difference in opinion on mental health or mental illness dependent on education level. For example, if certain ideas were more or less prevalent contingent on levels of education. Future research could include whether there is a class difference in views of mental health or masculinity amongst Muslim men.

Though this thesis was able to interview participants from a range of ages (from early 20s to early 50s), it would be important to consider an in-depth look at any differences between men of different age groups, as their age or generation affiliation may have an impact on their views or experiences of mental health. Conversations around mental health and mental illness are increasing, and we as a society in the U.K are becoming more understanding of mental illness. Therefore, witnessing this change may also have an impact on participants' views. This could be achieved through conducting focus groups with men of each age demographic. Following on from this, more in-depth studies could be conducted on the specific demographics mentioned by participants. For example, a study on Muslim male convert's mental health and their experiences of conversion as it could relate to their mental health. Additionally, a research could be conducted in relation to the religious denominations or backgrounds of participants, such as how Shia Muslims experience mental health specifically within their community compared with Sunni Muslims.

An expansion on the comparison between first, second, and third generation Muslims and their views and experiences of mental health would be worth investigating. Following on from this, research around mental health and refugees/people of migrant origin would be relevant for further investigation. In particular, how this may link to their experiences of

[485] Quote from Participant 12

trauma and recovery. Conditions such as Post-Traumatic Stress Disorder may be pertinent to study in this context.

The idea of Muslim men being a provider was prevalent in the majority of interviews. Many emphasised the importance of this idea as an underpinning of what it meant to be a Muslim man, as well as the pressure this sentiment had on an individual's mental health. It would be worthwhile to analyse this in relation to changing gender roles; bearing in mind the increase of Muslim women outperforming Muslim men in obtaining degrees.[486]

As a researcher with lived experience of mental ill health, it has been thought-provoking conducting a study on mental health. It would be enlightening to carry out research on researchers who both have experience with mental illness and research mental illness, to determine how this impacts them as a researcher. Furthermore, it would be pertinent to look at researchers who have personal experiences of mental ill health who research mental illness to determine the effects on themselves.

The role of the community was something regularly discussed amongst participants when talking both about the pressures faced by Muslim men and when seeking help for mental ill health as a Muslim man. As a possible topic for consideration, it would be productive to examine the role of the communities both as a protective and risk factor of mental ill health in more depth. One possibility would be a longitudinal study examining mental illness and the role of faith over time; looking at fluctuations in both. Additionally, more work could be done to explore the links and thoughts around the idea of community as it relates to Muslim men's social relationships and their mental health. This is linked to the ideas spoken about during my interviews, that many Muslim men felt they could not speak to many people about their emotions or when they had an issue.

The majority of the factors and themes mentioned by participants could be used as jumping-off points for future study. These include, but are not limited to: suicide, stigma, community, ethnicity, and culture. My study has covered these as part of an overall picture of the views and experiences of Muslim men's mental health in Wales. This study can be used for future researchers as initial points of view. Though suicide was not the main focus of this study,

[486] Jamie Doward, "Young Muslim Women Take Lead over Men in Race for Degrees," *The Observer*, April 2, 2016, sec. Education, https://www.theguardian.com/education/2016/apr/02/muslim-women-men-degrees-jobs-market-british-universities.

brief questions were asked. As male suicide is still a major concern in many countries across the world, with men accounting for three quarters of the worldwide suicides, it would be important to conduct a study into suicide specifically among Muslim men.[487] A study of this sort could allow for comparisons between Muslim male and non-Muslim male populations, examining whether faith or religiosity is a risk or protective factor regarding suicide.

As of 2024, the UK is experiencing a cost-of-living crisis, with organisations reporting the effects on mental health particularly in relation to anxiety over monthly costs-of-living. According to a survey from the British Association for Counselling and Psychotherapy, two thirds of therapists felt that the cost-of-living crisis and associated concerns are 'causing a decline in people's mental health'.[488] It would be pertinent to look at further impacts of the relationship between poverty and financial issues and mental health. This is especially important since the cost-of-living crisis may exacerbate poor mental health and have further negative effects on a Muslim man's mental health.

The idea of a Muslim ummah and how this concept may affect mental health, is another area for research. Some have acknowledged the link between the idea of the ummah and the experiences of vicarious trauma amongst Muslims.[489] One such case is the idea that many Muslims in the West may feel pain and experience effects on their mental health when Muslims in another part of the world are suffering. These links could be examined in light of recent issues involving Muslim-majority countries, such as the 2023 floods in Libya, or the ongoing conflict in Palestine.

There is an overrepresentation of Muslims, specifically Muslim men, in the UK prison system compared to the general population (18% for the former, and 7% for the latter).[490] These numbers have increased sharply over the last twenty years; doubling since 2002.[491] Many initiatives have been established to support and research these individuals, such as the

[487] Jo River and Michael Flood, "Masculinities, Emotions and Men's Suicide," *Sociology of Health & Illness* 43, no. 4 (2021): 910–27, https://doi.org/10.1111/1467-9566.13257. 910.
[488] "Cost of Living Crisis: Survey Shows Impact on Mental Health," accessed October 27, 2022, https://www.bacp.co.uk/news/news-from-bacp/2022/8-september-cost-of-living-crisis-survey-shows-impact-on-mental-health/.
[489] "Your Lord Has Not Forsaken You: Addressing the Impact of Trauma on Faith," Yaqeen Institute for Islamic Research, accessed October 23, 2023, https://yaqeeninstitute.org/read/paper/your-lord-has-not-forsaken-you-addressing-the-impact-of-trauma-on-faith.
[490] Georgina Sturge, "UK Prison Population Statistics" (House of Commons Library, September 8, 2023), https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf. 15.
[491] "Young, Muslim and Criminal: Poverty, Racism and Inequality in Bradford | LSE Research," November 9, 2021, https://www.lse.ac.uk/research/research-for-the-world/race-equity/young-muslim-and-criminal-how-poverty-racism-and-inequality-have-impacted-the-pakistani-community-in-bradford.

PRIMO project at Cardiff University, and the work carried out by Muslim Hands.[492], Further research could be established to examine the mental health of male Muslim prisoners and how this relates to reoffending, and how their experiences prior to prison may shape their recovery. A report from the organisation Maslaha suggested that Muslim men in prison have experienced incidents of being treated with disrespect by staff, not receiving basic care, and other negative occurrences.[493] Such a study could help the welfare of those in prison.

Recommendations for Practitioners

In this present case, practitioners are considered to be anyone working in a support role for Muslims. This could include teachers and lecturers, social workers, youth workers, as well as individuals working more specifically in mental health. Based on the findings of this thesis, I would like to provide recommendations for practitioners – whether Muslim or non-Muslim – working with Muslim men experiencing mental ill health or more broadly informing policy makers on the subject of Muslim mental health. The first recommendation is to ensure that practitioners have an understanding and awareness of how difficult many Muslim men find speaking about their experiences of mental health. As mentioned in an earlier chapter, Cardiff University created a programme entitled "Understanding Mental Health in Muslim Communities", to provide information to practitioners on the topic. It is my recommendation that courses like this become compulsory for those who may be working with Muslims experiencing mental ill health. It is important for practitioners to have an increased level of religious literacy to ensure adequate support. Courses such as this could be beneficial not only for practitioners but also for imams and Muslim community leaders. Many Muslim mental health organisations already offer training in mental health for imams and religious leaders, and I recommend that this is expanded to all mosques in Wales where

[492] "Prison-Based Interventions for Muslim Offenders (PRIMO)," Cardiff University, accessed November 24, 2023, https://www.cardiff.ac.uk/research/explore/find-a-project/view/2614542-prison-based-interventions-for-muslim-offenders-primo.; Muslim Hands, "Prisoner Rehabilitation and Resettlement," June 1, 2015, https://muslimhands.org.uk/latest/2015/06/prisoner-rehabilitation-and-resettlement.
[493] "Time_To_End_The_Silence_CJ_Report_Maslaha.Pdf," Dropbox, accessed November 26, 2023, https://www.dropbox.com/s/5kq6m7g55sbv91e/Time_To_End_The_Silence_CJ_Report_Maslaha.pdf?dl=0. 13.

possible.[494] This could be achieved through a centralised agency such as the Muslim Council of Wales.

It is important for practitioners to have an understanding of Islam, and by extension, Muslim mental health. There are factors that may be unique to a Muslim's experiences of mental health and mental illness because an individual's Muslim identity or cultural background may have an impact on how they interact with mental health services. Such factors may positively or negatively shape their mental health experiences. It is not imperative that all practitioners need to undertake a course in *fiqh* or join a *dar-ul-ʿuloom*, but those with Muslim clients should be prepared to understand the importance of certain factors or rituals in Muslim's life, such as the impact of prayer or fasting.[495] Yet, it is still important for practitioners to not view Muslims as homogenous, as it would be impossible for all 67,000 Muslims in Wales to practise Islam in exactly the same way. A Muslim may still find the impact of prayer helpful, even if they do not necessarily pray regularly.

Many voluntary organisations within the mental health sphere work in partnership with the NHS Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs). These systems and boards (previously known as Clinical Commissioning Groups (CCGs)), give funding and opportunities; but many smaller mental health organisations which provide specialist religiously appropriate support may not feel confident in submitting proposals to tender. I believe the onus is on statutory organisations to engage and interact with these smaller, specialist groups to ensure the most appropriate support for the patients under their care.

Recommendations for Communities

Many of the individuals interviewed spoke about the importance of the community in both contributing to poor mental health and improving mental health outputs. The definition of *community* in the context of this thesis and recommendations can mean the wider Muslim

[494] Inspirited Minds July 2 and 2017, 'Free Mental Health Training Course for Imams - Inspirited Minds', 2 July 2017, https://inspiritedminds.org.uk/2017/07/02/free-mental-health-training-course-for-imams/, https://inspiritedminds.org.uk/2017/07/02/free-mental-health-training-course-for-imams/.
[495] *Fiqh* is defined here as Islamic jurisprudence. A *dar-ul-uloom* is an Islamic seminary which produces many imams in the UK.

community in addition to the community in the participant's local mosque, or the small Muslim community in their area of residence.

Increasing a community's general understanding of mental health and wellbeing and how to spot the signs of conditions such as depression and anxiety, or how to approach conversations around these topics, could lead to better outcomes for those experiencing mental ill health. It could encourage individuals suffering to seek help or interventions at an earlier time.

Many initiatives are established in communities to encourage men to speak about their mental health, often in so-called "safe spaces" such as barbershops or at football clubs. These spaces are often associated with less pressure than traditional talking therapy routes, such as seeing a counsellor or calling a mental health support line. One such example of this is *Shave Space, '*a project aimed to empower the relationship between mental health and the barber shop', where a barber trained in mental health issues can speak to his clients whilst they are having a haircut.[496] There is emerging literature which suggests the positive affect barbershops have on men's mental health.

Ogborn et al., wrote about barbershops in the UK and their use as a setting for supporting men's mental health during the COVID-19 pandemic.[497] Their research showed that men may prefer "supportive strategies that reframe help seeking as reflecting conventionally masculine attributes such as "being brave" and "in control", allow for meaningful interpersonal connections, involve trusted providers and take place in familiar community settings".[498] Therefore, a recommendation for communities is to establish such community settings for men to speak about their mental health; settings which are already spaces attended by men that can be reframed into supportive environments. The success of barbershops in promoting positive health outcomes has already been correlated to improvement in physical health conditions such as hypertension and prostate cancer.[499] However, these could be replicated in terms of mental health. Though the aforementioned study was conducted during the COVID-19 pandemic, there is no reason why they may not

[496] "ShaveSpace (@Shave_Space) / Twitter," Twitter, accessed October 8, 2022, https://twitter.com/Shave_Space.
[497] Georgina Ogborn et al., "Barbershops as a Setting for Supporting Men's Mental Health during the COVID-19 Pandemic: A Qualitative Study from the UK," *BJPsych Open* 8, no. 4 (July 2022): e118, https://doi.org/10.1192/bjo.2022.520. 1.
[498] Ibid.
[499] Ibid.

work more generally outside of such a special circumstance. The study also cited the increased affect the pandemic had on BAME communities "who have contracted and died from COVID-19 at significantly higher rates compared with White communities, as well as facing relatively higher levels of stress and mental health problems linked in part to precarious housing, employment and financial conditions".[500] As a result of the pandemic, BAME communities (of which the majority of Muslims are a part of) faced higher levels of mental health issues. Therefore, community initiatives to aid mental health support would be extremely useful.

Participant 17 also discussed the need for an environment for Muslim men to discuss their emotions. When asked what could be done to help Muslim men with their mental health, he said,

> '*You could do stuff like … talking about it, having a conversation about mental health with Muslim men. That's probably the biggest thing you could do, I promise you, because we got a room full of men talking about their emotions… They're going to go in there with their chest held high, but then they're going to walk out with sobbing tissue and crying, you know? And it's nice. Yeah, they should have … the courage and the pride to actually speak about emotions; because if they do not, they just hold them back and, in the years to come, it will affect them.* '[501]

He felt that having simple conversations about mental health with Muslim men would help them to express their emotions rather than hiding them and keeping them to themselves. This is something which Shave Space and other groups like it are doing, and something that other communities and mental health organisations could hold initiatives to achieve. He also acknowledged the possible repercussions of not speaking about one's mental health; that it could affect them negatively in the future. We could link a statement such as this as a possible reason for male suicide rates being higher than females'. This is because, according to this participant, men hold in their emotions, and not seek support until later in life when perhaps their mental health becomes worse.

Participant 18 expressed the desire to have a group session where Muslim men can speak about their mental health in a setting that is more casual than a counselling setting, suggesting,

[500] Ibid.
[501] Quote from Participant 17

> '*I just wish that like, we could have like a group session just among us [as] men and not in a counselling kind of way; but more in the fellowship kind of way. Yeah, I think that would be really nice. And I think… there needs to be a level of maturity to let that happen. So yeah, that would be really helpful.* '[502]

Group sessions to provide mental health support are an aid which are often already used in many communities. In South Wales, there are groups already set up for men's mental health by Cardiff Blues Brothers and Innovate Trust.[503] Though these groups exist for men generally, it would be beneficial to establish groups solely for Muslim men; or, to go further, Muslim men from each cultural or ethnic background. Through such endeavours, these Muslim men may benefit from a "fellowship" setting as Participant 18 described.

Other Recommendations

Many organisations including the All-Party Parliamentary Group on Issues Affecting Men and Boys have called for the need for a strategy on men's health, with an inclusion of mental health, following the UK government's announcement of a women's health strategy.[504] It has been acknowledged that many men are vulnerable to mental health difficulties but are invisible in relation to policy.[505] Therefore, it is recommended that improvements are made at a governmental level in order to best support men, and in particular Muslim men by acknowledging cultural and religious backgrounds and differences. One possibility would be implementing sessions in schools specifically focusing on mental health for boys and how to deal with their emotional health as they transition into men.[506]

In 2016, Mark Drakeford, then the Welsh Minister for Health and Social Services, produced a written statement on Improving Men's Health in Wales.[507] The statement provided an overview of the Welsh government's aims in relation to men's health, with a section on mental health. They implemented a ten-year strategy called "Together for Mental Health". However, the delivery plan is limited in its provision for men, with only a brief mention of

[502] Quote from Participant 18
[503] "Mental Health," *Cardiff Blues Brothers* (blog), accessed February 25, 2023, https://www.cardiffbluesbrothers.com/mental-health/.; "Men's Group," Innovate Trust, accessed February 25, 2023, https://innovate-trust.org.uk/services/mens-group/.
[504] Alan White and Martin Tod, "The Need for a Strategy on Men's Health," *Trends in Urology & Men's Health* 13, no. 2 (2022): 2–8, https://doi.org/10.1002/tre.842. 2.
[505] Ibid.
[506] Ibid.
[507] "Written Statement - Improving Men's Health in Wales (26 February 2016)," GOV.WALES, February 26, 2016, https://www.gov.wales/written-statement-improving-mens-health-wales.

a focus on middle-aged men as part of the strategy.[508] Furthermore, within this plan, no guidance or strategies were given for supporting Muslim communities. There was a brief mention of encouraging culturally appropriate support for Black and Minority Ethnic communities, but this was reduced to one bullet point within the entire report.[509] As no guidance or delivery plans have been published for 2023 and beyond, a recommendation as a result of this present research is to include strategies specific to men and Muslim communities within further plans.

Conclusion of Discussion Chapter

This chapter evaluated the main research question of:

"What is the impact of Islam and Muslim identity on experiences of mental ill health among Muslim men in south Wales?"

It examined this question by looking at the participants' answers in the interviews in relation to masculinities and the expectations of men and how this may link to their mental health.
It has made the argument that different views of Muslim men due their demographic characteristics, such as their ethnic backgrounds or age, influences their views and experiences of mental ill health. Additionally, their views and experiences are impacted by their perceived notions of masculinity precipitating from their background. More specifically, it discovered that certain aspects in relation to mental health were more common in some cultures compared to others.

This chapter has cemented the concept that ideas around male roles, such as being a breadwinner and financially providing for their family, have an impact on a Muslim man's mental health. Though this notion was often shared as a cultural expectation, rather than a religious one, this was not distinct. As Participant 4 succinctly noted, "*I would say the role of the man is still, very much seen, as the breadwinner. And that definitely does not seem to*

[508] Welsh Government, "Together for Mental Health Delivery Plan: 2019-2022" (Welsh Government, 2020), https://www.gov.wales/sites/default/files/publications/2020-01/together-for-mental-health-delivery-plan-2019-to-2022.pdf. 18.
[509] Ibid, 10.

be changing as a cultural identity".[510] With participants feeling a sense of identification to both their culture and their religion, it is understandable that these cultural expectations may still be prevalent, especially as these cultural notions are not explicitly forbidden within Islam. This, coupled with the idea that a man needs to be strong for their family, meant that participants often felt as Muslim men that they had no one to speak to about their mental health.

Furthermore, this chapter has explored the ideas of masculinity, mental health, and Muslim men in Wales as discussed in interviews with participants. It ended with an overview of recommendations for Muslim communities, practitioners, and the general community on Muslim men's mental health. It has given a detailed examination of the scope for further research based on the findings and analysis in this study.

Recommendations have been provided based on the findings from my interviews and literature review. These recommendations are intended for statutory, voluntary, and other organisations working within the mental health sector, as well as anyone who may come across Muslim mental health in their field. It is my express goal that this thesis helps to exact real change in the mental health field, and for organisations to engage seriously with these recommendations.

[510] Quote from Participant 4

CHAPTER 6 – CONCLUSION

This thesis has provided an overview of the views and experiences of Muslim men's mental health in South Wales, as well as an overview of Muslim mental health in the UK. It has given an in-depth review of the existing literature around these topics and explored the gaps around mental health in Wales and Muslim men's mental health that this thesis has filled.

The Introduction and Literature Review sections of this thesis allowed for contextual and background information and research to be presented in relation to this thesis. During the Literature Review chapter, this thesis explored definitions of mental health and mental illness to ensure their use was continuously appropriate in this work. It set out the gaps which exist in the existing literature that this thesis fills; namely, a qualitative study on Muslim men's mental health in a UK context.

The Literature Review introduced many of the key themes which were later addressed within this work. Concepts around religion and spirituality were discussed and how these may relate to mental health. These wider ideas were first examined due to their prevalence within research, compared to the scarcity of information on Muslim mental health, and Muslim men's mental health more particularly. It then discussed specificities that exist within many Muslim cultures; namely the ideas of djinn and exorcisms and how they relate to mental health and mental illness.

It was important for this thesis to discuss the Muslim community in the UK and provide contextual research around Muslims in Wales. This helped contextualise participants' lived experiences, especially how their perceptions of identity shape their views and experiences of mental health and mental illness. This is also the first study of Muslim men living in Wales' views and experiences of mental health and mental illness.

The Literature Review also examined external factors which may contribute to poor mental health or mental illness. The stigma of mental health is one which has been researched in detail, and arguments suggest that this can prevent individuals from seeking help for their mental illness, or even acknowledging there is an issue in the first place. Islamophobia and

trauma were also identified as potential contributing factors to poor mental health, and research on this impact was discussed.

This chapter ended by noting the effects that the COVID-19 pandemic had on mental health. Though the pandemic occurred during this PhD process, there have already been initial attempts to document and research these effects. This was a separate section rather than embedded into the wider literature review as it gives a chronological narrative of how much mental health research is developing, especially mental health research which has an element of religious studies. Emerging Literature and the COVID-19 pandemic are inextricably linked, as mental health became an increasing concern during this specific period and the years since

These key themes which were highlighted within the Literature Review were mirrored in the questions and topics I asked participants. I examined whether the outcomes of previous research mirrored that which was found in my study.

The Methodology section examined the best methods to conduct this research, as well as the importance of using interviews and qualitative techniques for mental health studies. This section was reflective in nature and discussed my positionality as a researcher and the impact this study may have had on the participants. The theories utilised in my epistemological framework were Durkheim's Fundamentalism, and to a lesser extent, Said's Orientalism. Durkheim's theory was found to be the most apt for this thesis. Though other theorist's ideas were explored, such as Weber's and Marx's views of religion, they were not suitable for the interpretation needed for this thesis.

Within the Methodology chapter, it was established that the most appropriate theory for interpreting the data was Grounded Theory. Therefore, those aforementioned theories of religion were grounded in evidence from the data once it was collected. The Methodology also briefly covered the use of religiosity questionnaires and how some of those methods could be attributed to the questions of religiosity that I asked during the interviews with participants. One aspect of this thesis which came about due to Grounded Theory was the use and application of theories of masculinity and how these relate to mental health and religion; in addition to how understandings of what it means to be a man, culturally or religiously, also shape these views and experiences. This section discussed the sampling methods utilised and how this may have impacted the selection of participants. It covered

how COVID-19 had a huge impact on research methods, including the recruitment of participants, sampling, and on the interviews themselves.

I sought to ensure that this thesis was incredibly reflective in nature. As an individual who has dedicated much of the last seven years to working, volunteering, and studying in the field of Muslim mental health, I felt it was continuously important to examine my positioning as a researcher, any biases I may have had, and the general impact of someone with lived experience of mental illness conducting a study on mental health. I aimed to address any concerns and biases, and ensure I was learning and developing from each interview conducted and each piece of research read. Similarly, I placed a huge emphasis on ethical considerations during this study. Both due to the stringent ethical measures put in place by my university and to my lived experience, I wanted to ensure that those individuals who were kind and brave enough to participate in this study were given the highest level of anonymity. Many participants expressed that I was the first person they had ever spoken to about their mental health, and so I felt an extra duty of care towards them.

It was important that I covered both the impact and limitations of this thesis. The impact of this study firstly fulfils an existing gap within the literature. Secondly, the impact will be measured through the recommendations made, and whether or not the recommendations will be accepted or implemented by statutory and voluntary organisations. Many of the limitations of this study were due to factors surrounding COVID-19. The Methodology chapter reflects that had circumstances been different, I would have been able to gain more participants and to hold in-person focus groups to enable a deeper understanding of some of the topics that participants raised.

Within the Data chapter, this thesis covered the key themes which were raised by participants during the interviews. It also gave an overview of previously mentioned barriers to Muslims seeking mental health support and assessed these with the evidence found in the interviews. It then looked at ethnic and cultural backgrounds and whether these had an impact on the views and experiences of the Muslim men participant's mental health through examining what they felt it meant to be a man.

During the Discussion chapter of this thesis, I examined some of the key themes in greater detail by analysing quotes from the participants in relation. The beginning of this chapter covered theories of masculinity and how participants defined being a man, as well as the

effects of the gender roles and responsibilities of Muslim men on their mental health and notions of masculinity. It also considered the use of Islam as a coping mechanism for mental health and mental illness, going back to one of the initial research questions asking whether Islam was a protective or risk factor for mental ill health.

Within this work, though I am unable to definitively prove whether any particular ethnic group are more at risk than others, it was interesting to consider the role of migration on a participant's mental wellbeing. Though I was unable to interview refugee men in this thesis, as due to the pandemic I was unable to access certain groups, and it was out of the scope of my research, the topic would be of significant importance for future research.

This thesis is an original piece of work which has covered many themes within the subject of Muslim men's mental health in detail and has given a wealth of options for further study based on this research. It has also included many suggestions for services and practitioners to improve support for Muslim men's mental health.

From the conception of this thesis, the intention has been to make an impact on the mental health support sector as a result of the findings. As mentioned, this thesis is the first of its kind which covers Muslim men's mental health in south Wales. It is also the first in-depth study to look at the relationship between Muslim men in the UK, their religion, culture, and their mental health. Through the research, I have uncovered views of mental health differing by cultural backgrounds and how this may have a positive or negative impact on views of mental health and engagement with mental health services.

This work has the potential to have a huge, positive impact on the field of British Muslim mental health. It is an unprecedented study; one which examines Muslim men in south Wales through lenses of religion and masculinity. This work will lead to wider questions around mental health and masculinity, in particular with the rise of online "incel" culture and the like.[511] As stated previously, Participant 16 noted he saw misogynistic and '*problematic attitudes towards men and women'*[512] amongst Muslim men. These views could be further explored in a piece of work that looks at the relationship between Muslim masculinity and

[511] A. J. Willingham, "Misogynistic Influencers Are Trending Right Now. Defusing Their Message Is a Complex Task," CNN, September 8, 2022, https://www.cnn.com/2022/09/08/us/andrew-tate-manosphere-misogyny-solutions-cec/index.html; *Incel* is defined as "Involuntary Celibate".
[512] Quote from Participant 16

femininity and the changing roles of both, and how that may impact on an individual's mental health.

One of the goals of this thesis was to ensure that it would have an impact on the types of people interviewed: regular Muslims in Wales, and the wider UK, not just impacting those in academia. I want to enable statutory and voluntary organisations working in mental health, or working with Muslims who may experience issues relating to mental health to apply my recommendations and learn from this study.

This work has the potential impact to change and improve mental health services to ensure that Muslim men feel able to access them. Through services acknowledging the points made in this thesis, they can further improve their availability and remove barriers between them and those in need.

Many participants thanked me for conducting this work, which meant that the importance of this study is further emphasised because the individuals that this research is intended to impact could see the need for it. Since this study examines Welsh Muslims, the research may inform Senedd policies involving wider Muslim engagement with mental health services and preventing worsening mental health amongst Muslim men. Furthermore, this thesis may encourage Welsh mosques to adopt relevant recommendations in order to maintain positive mental health within their congregations in addition to being able to recognise poor mental health. I have provided details of where further research may be possible.

It is important to acknowledge that mental health and mental ill health do not exist in a vacuum; and we cannot ignore surrounding factors that may contribute to these, such as social determinants or economic factors. Through recognising this, academics, policymakers, and those in the mental health field should also focus on lobbying for change in all the factors that contribute to poor mental health to engage with the government and provide holistic approaches to the issues.

Overall, it was my intention with this study to not only contribute to research in academia, but to also impact and make real change to the lives of Muslim men concerning their mental health. To discuss men's mental health and provide recommendations to encourage the positive change in attitude, access, and support has been extremely important for the field. It is my hope that the recommendations from this thesis are accepted and implemented by

various organisations, including those which are statutory and voluntary, within the UK. To incorporate these recommendations may ensure better outcomes for Muslim men seeking mental health support; thus, improving the mental health of the population more generally.

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